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WISCONSIN MEDICAL JOURNAL

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M.D.S.

Express your professional pride . . . President Viste expresses the concerns of physicians who are having an identity and image crisis. He reminds his colleagues that "these attitudes can become a self-fulfilling prophecy. I encourage each of you to be mindful of the tremendous impact that your comments and verbalized thoughts have on the attitudes, feelings, and opinions of those you work with in the healthcare delivery system" (see page 5).

New technologies in diagnosis and classification of malignancy . . . A Marshfield physician reviews the development of new technologies over the last twenty years that have improved physicians abilities to diagnose and classify many malignancies. He concludes by stating, "In an era of cost-containment, expensive technology must be applied selectively and appropriately. When used in this fashion it will help us more accurately diagnose our patients, and prevent the most expensive mistake of all—the wrong diagnosis!" (see page 14).

Jesse's escape . . . A Madison physician, in the "Soundings" feature, presents a very intense and dramatic message on the ethical problem relating to the patient's right to die (see page 23).

Past Presidents' Task Force to review liability issue . . . In December the SMS Board of Directors' Executive Committee created a special task force of past presidents of SMS to review all relevant data regarding proposals that encourage modification of both the old Patients Compensation Panels and the new Mediation Panel System. Russell F Lewis, MD chairs the task force (see page 24).

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WISCONSIN MEDICAL JOURNAL (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Society's Board of Directors. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. Unsigned Editorials express views consistent with the policies of the State Medical Society of Wisconsin. Signed Editorials express personal views of the author for which the Society takes no responsibility. Neither the Editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus," "Hospital Literature Index," and "Cambridge Scientific Abstracts."

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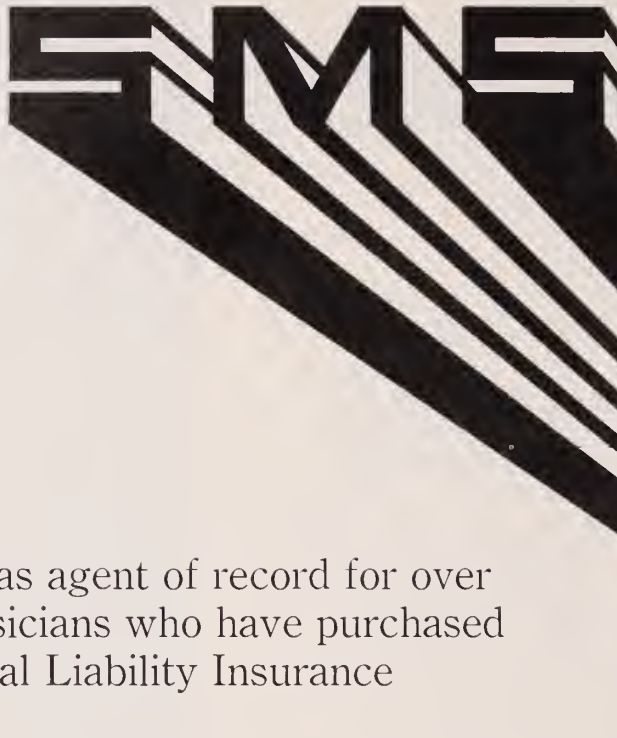
THE STATE MEDICAL SOCIETY OF WISCONSIN, created by the Territorial Legislature in 1841, represents over 6700 member physicians in Wisconsin, comprising 55 county medical societies and 28 medical specialty sections. The purpose of the Society is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society include continuing medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, services for physicians, operation of a Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal*



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Kenneth M Viste Jr, MD

Express your professional pride

THE REFRAIN IS ALL too familiar. We hear it in hospital corridors, in the doctor's lounges, and at medical meetings—"I've had it," "It's time for me to get out," "It just isn't the same any more." Physicians are having an identity and image crisis. Public opinion surveys have shown that while patients respect and trust their own physicians, the profession has gradually been slipping in terms of its perception by the general populous. We see, too, few and fewer applicants to the country's medical schools causing some to express concern that this shrinking pool of applicants means that the doctors our system will be producing in the future will not be representative of the "best and the brightest." Some say that these people are finding intellectual and academic attractions elsewhere; that new careers are attracting those who would make the best and most capable physicians.

My concern, and the purpose for this President's Page, is to remind my colleagues that these attitudes can become a self-fulfilling prophecy. I believe that we became physicians for the opportunity to serve our fellow man and to contribute something to the world. In fact, the helping and nurturing aspects of medicine, coupled with society's approbation and the intellectual challenge presented by the practice of medicine, have been the primary reasons most of us have chosen this as our profession. In these times it is critical that physicians have a positive attitude about our profession and a continuing interest in its future. The "malcontents" who bemoan the rapid disappearance of quality medicine are but a very small minority. As I have done all year long, I call on the physician members of the Society to harken back to their beginnings and to think about their feelings as they graduated from medical school; recall the pride in becoming a part of this most noble of professions; recall the awe at those who have practiced medicine before us; and think about the satisfying interactions we have with our patients; with our ability to help mankind and to make the world a better place.

The publicized negative attitudes too often expressed by some of our colleagues have a ripple effect. Wisconsin is in the midst of a nursing shortage that is rapidly approaching crisis proportions. Other members of the healthcare team, such as physical therapists, laboratory technicians, and pharmacists are also in short supply. As leaders of the healthcare team, physicians must take an active part in helping people view the healthcare professions as worthwhile careers. We must help current and potential nurses, pharmacists, physical therapists, and others to recognize the basic human values that are inherent in providing healthcare and to remind them of the incredible contributions they are making to our society—that helping others is truly a laudable profession. So that their numbers will not dwindle further, we, as physicians must recognize that many of the stresses and strains that affect us as physicians every day most probably affect nurses even more. Various studies of stress have shown that the most stressed person in the healthcare team, in fact, has been the nurse.

We all are extremely cognizant of the major contributions these healthcare professionals provide to the overall availability of quality patient care. We must seek answers that will extend the average working career of a nurse, which ironically is only six or seven years. We must do our part as physicians in promoting and emphasizing the value of

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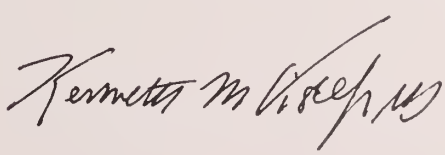

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nursing care and that of the professionals who provide other healthcare services yet remain cognizant of the stresses and strains on their everyday professional lives. We must work with educators, hospital administrators, and government at the state and federal levels to develop more innovative ways to train nurses and other healthcare professionals. We must also look to ways they can be fairly compensated commensurate with their training and responsibility. Within our own institutions, we must look at how various responsibilities in the healthcare setting may be delegated and shared.

Perhaps we need to look toward a new class of members for the healthcare team, not unlike military corpsmen, to provide the necessary skills and compassion required for successful healthcare? I encourage each of you to be mindful of the tremendous impact that your comments and verbalized thoughts have on the attitudes, feelings, and opinions of those you work with in the healthcare delivery system. You are viewed as the leader; you set the tone; you set the tenor, for these professionals' approach to their patients. Take pride in your profession and express that pride at every opportunity.■

Wisconsin Medical Journal deadline for writing contest is January 31

The Editorial Board of the *Wisconsin Medical Journal* reminds Wisconsin medical students and residents that the deadline for submission of papers to be considered for its writing contest is January 31.

Students enrolled in either of Wisconsin's two medical schools and residents actively training in the state are eligible to submit a scientific article on the topic of their choice to the Editorial Board of the ***WMJ***.

Authors considering submission of an article to the writing contest should note that among the considerations the Editorial Board will use in reviewing scientific manuscripts are: scientific validity, the importance of the content of the manuscript, originality, appropriateness of interpretations and conclusions, readability and organization, and clarity of the writing.

A recognition certificate and cash award in the amount of $500 each to the medical student and the resident who submit the winning manuscripts will be presented to them at the 1988 SMS Annual Meeting in Milwaukee, April 28–30.

Judges for the contest will be the Editorial Board of the ***WMJ*** which shall be the final authority in all decisions regarding manuscripts.

For further information or for submission of entries contact Mrs Mary Angell, Managing Editor, *Wisconsin Medical Journal,* PO Box 1109, Madison, WI 53701, or phone toll-free 1-800-362-9080 or 1-608-257-6781; or Richard D Sautter, MD, Medical Editor, 510 North St Joseph Ave, Marshfield, WI 54449, or phone 1-715-387-5107.■

Food poisoning from fish

Scombroid-type food poisoning is associated with fish and named for the family of fish, *Scombridae,* in which it was first described. But a report in Friday's *Journal of the American Medical Association* suggests this type of food poisoning can occur with other fish varieties and may be more common than earlier thought. Paul Etkind, MPH, of the Commonwealth of Massachusetts Department of Public Health, Jamaica Plain, and colleagues describe a case where five people developed scombroid poisoning symptoms although they did not eat *Scombroidae* fish. The outbreak was tied to improperly stored and thawed bluefish. Other, similar outbreaks have been reported, the authors say, noting this type of poisoning can be prevented. "Given the increasing popularity of fish in the American diet, the potential for scombroid poisoning is now greater than ever before," they say. "Cooperative efforts by physicians and public health officials can help to minimize morbidity."—***AMA Brief Report***

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"Trivial knowledge"—unimportant?

A FRIEND AND I were discussing the phenomenon of "fads." We talked about fashion fads—Nehru jackets in the 60s, clown-width lapels and ties in the 70s, and (particularly regrettable) that benighted period in the 80s when every item in one's wardrobe except the shoes had to be in "alligator." We touched on medical fads —hyperbaric oxygen therapy in the 60s, and "patterning" as a therapy for developmental delay. "And we can't forget 'trivia,' " my friend said, "No one is playing TP anymore."

He was referring to Trivial Pursuit, a game very popular in the early 80s, in which one's mastery of our culture was put to the test. In general, two types of player were quickly identified: those who could get 1 out of 50 questions right, and those who could get the other 49. The two-percenters justified their dismal showing by claiming that the game dealt exclusively in "unimportant" facts and was not "relevant."

This brings up the subject of "trivia." Most people like TP; it is entertaining, not intellectually taxing, and virtually guilt-free, sort of like salted peanuts for the mind. Some people see it as mind-clutter. Who cares, for instance, that a golf ball has 336 dimples in its surface? Or that Billy The Kid was born in Brooklyn? Or that the expression, "the whole nine yards," indicating a massive expenditure of effort or resource, refers to what once was the load size of a standard dump truck, and not to football?

Consider, however, the loss the medical profession sustained when it deemed a knowledge of the classics unnecessary to the curriculum. Students lost the use of beautifully descriptive language as a learning tool, particularly of anatomy. It is sad that we retain the classic names, but no clue as to their original meaning. How much easier anatomy would have been if we could have referred to the glassy fluid, the horse's tail, the playground, the fortune teller, the doorman/tickler, or the witness.* Early anatomists were nothing if not poetic.

Unimportant, you say? *Trivial*, you say? Consider then the origins of the word "trivia." "Trivium" referred to a joining of three roads. In the Middle Ages it referred to the subjects to be mastered for a BA degree: grammar, logic, and rhetoric. Subsequent mastery of the quadrivium (music, arithmetic, astronomy, and geometry) earned one the master's degree, and completed one's liberal arts education. Thus, "trivia" derives in part from the word for that knowledge considered basic to one's education. A second word of origin is "trivialis," indicating "commonplace" or "ordinary." Note that it does not imply "unimportant." Common things are just that—common to everyday life. *Necessities* of everyday life, if you will. Bread may be ordinary—but it is not unimportant if you are hungry.

Back to TP. If it failed as a game, it was because it failed as a concept (and also because few of us seek out opportunities to demonstrate our ignorance publicly). Trivial facts are not important in and of themselves, but they are critical parts of the whole of one's education. It is impossible to decide which facts will be unimportant to us and how much "trivial knowledge" is enough. To argue against "trivia" is to argue against education itself.

This is a foreign concept to those of us who came up in our specialty-oriented educational system, where college preps don't take shop courses, premeds don't take music history, and internists and surgeons regard each other with polite contempt. One might argue that the purest form of specialization is bigotry—not a trivial matter, at all.

A colleague at our local hospital was lamenting recently the passing of the rotating internship. "It made you a better doctor," he was saying. "It helped you understand the problems inherent in other specialties. It helped you better appreciate your consultants point of view."

Ten years ago, steeped in a specialization-oriented medical curriculum, I laughed at the idea of a rotating internship, just as I had laughed at my dad when he talked about his time in the Army being a growing experience. I'm not laughing now. I'm just wondering why I don't feel as smart now as I did then. I made a decision back then about what was "trivial" to me, and what wasn't. I'll spend the rest of my life wondering if I was right.

—*Jeffrey H Lamont, MD,* Wausau

*vitreous humor, cauda equina, areola, omentum, clitoris, and testis

O R music
(Surgical suite sonatas)

SEVERAL YEARS ago I promised Editorial Board member Dean Connors that I would never again write another editorial relative to my musical preferences and dislikes. However, this is a different situation as this is about music in the operating room.

Several years ago when I was working at Hospital San Pablo in

Bluefields, Nicaragua, one of the things that I thought was particularly strange was the music piped into the operating room. Those were happier days in Nicaragua where on the east coast there was total integration, although all communication was in three languages (English, Spanish, Miskito Indian). One other interesting aspect at that hospital was El Commendante, local chief of the Garde Nacional. He had a keen interest in surgery and loved to watch operations, so he was a frequent observer in the OR.

But I digress. This is about background music in operating rooms closer to home. Personally I find being "Under the Apple Tree" with the Andrews Sisters very pleasant and something like "Sleepy Lagoon" very soothing. However, some of the younger people describe the latter as sedating. I am inclined to favor the Big Bands but I have a feeling that some of the younger staff people might prefer the current tuneless ditties with incomprehensible lyrics. But when it comes time to close the abdomen, you can't beat the US Marine Corps band belting out stirring Sousa marches.

—*Victor S Falk, MD,* Edgerton

"Quality assurance" —rebuttal

IN THE EDITORIAL "Quality assurance" (***WMJ,*** November 1987, page 8) Doctor Boulanger's assertion is correct when he states the medical profession has been concerned about quality for many years. However, the need for formalized quality assurance was recognized in the early 1900s by the American College of Surgeons and resulted in the first hospital survey in 1919. In that survey of 692 hospitals with 100 or more beds, only 89 hospitals were found to meet minimum standards necessary to provide adequate care. Quality assurance activities were continued by the American College of Surgeons until 1951. In 1951 the JCAHO was formed by the American College of Surgeons, the American College of Physicians, the American Hospital Association, the American Medical Association, and the Canadian Medical Association. The JCAHO, since 1966, has emphasized standards for hospitals that assure an optimal achievable level of care.

Recently, the emphasis in quality assurance has become more outcome-oriented. Thus, the quality of care provided by individual physicians becomes an area for evaluation. Variations in practice can be explored and if necessary, educational activities for physicians undertaken to improve less than optimal care. The enhancement of quality assurance to develop comparative statistics for physician performance takes quality assurance beyond Doctor Boulanger's realm of one patient-doctor-hospital relationship. Physicians no longer just evaluate themselves as Doctor Boulanger suggests, but rather are evaluated in comparison to and by their peers.

Established industries often become complacent. Witness the US auto industry in the 1950s and 1960s. Quality measurement and assurance were deemphasized since no other country in the world manufactured as fine an automobile as Detroit. However, quality was not as good as that found in foreign automobiles, and the US has never been able to recapture the quality image it lost to foreign competition. Like the auto industry, can the medical profession afford to be complacent about quality assurance? Can we afford not to evaluate and document the quality of care we provide?

In a field as complex as medicine, the opportunities for improvement and optimization of care are infinite. To decry the effort to measure and assure quality is to deny the opportunity to educate and demonstrate human concern.

—*George A Pagels, MD,* Marshfield■

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Severity and types of head trauma among adult bicycle riders

Edward Belongia, MD; Hank Weiss, MPH; Michael Bowman, MD; and *Parichat Rattanassiri, MD,* Madison, Wisconsin

ABSTRACT. *A retrospective review of bicycle-related head trauma in Madison, Wisconsin was carried out during the fair weather months of 1981–1984. One-hundred and eighty-seven (187) cases of head injury were identified through review of emergency department and inpatient records. Thirty-three percent (33%) of the cases had injuries of moderate severity and 3% sustained severe or life-threatening injuries. Thirty-two percent (32%) had evidence of brain injury. Within the brain-injured group, 55 (93%) had a concussion and 4 (7%) had an abnormal computerized tomographic (CT) scan. One-hundred and four (56%) of 187 patients were contacted for followup information. There was no significant association between type of collision and severity. Most serious injuries took place under daylight and dry conditions and did not involve motor vehicles. Only 1 of 104 respondents to the questionnaire was wearing a helmet at the time of injury. The results show that transient loss of consciousness or amnesia occurs commonly among bicycle riders who require emergency department treatment for head trauma.*

Key words: Head trauma; Bicycle-related injuries; Helmet use; Emergency treatment; Adult bicycle riders

BICYCLES HAVE become an important mode of transportation in the United States. The number of bicycles in this country has increased from 28 million in 1960 to 105 million in 1983.[1] This has been accompanied by a significant increase in bicycle-related morbidity and mortality, particularly among older riders. Of the 1100 bicycle-related deaths in 1982, 67% of the victims were over 14 years old. In 1960 only 22% of the 460 fatalities were in this age group.[1] According to the Consumer Products Safety Commission (CPSC), bicycling is the most common cause of recreational injury, accounting for over 570,000 emergency department visits in 1983.[2] Epidemiologic studies indicate that head trauma is associated with the more serious injuries.[3]

This study was designed to retrospectively evaluate the type and severity of head trauma in adult bicycle riders and describe injury circumstances along with rider characteristics. The study took place in Madison, Wisconsin where there are an estimated 25,000 college students who ride bicycles among a total population of 175,000.[4] The age range of the study group was restricted to adults for two reasons. First, little literature has covered this age group despite an increasing proportion of fatalities among adult riders during recent years. Secondly, for followup purposes it was thought that recall, consent, and cooperation would be easier to achieve and more reliable among older riders.

METHODS. Emergency department record review. Emergency department patient registrations or log books from three of the four general hospitals in Madison were reviewed for the period April 1 to October 31 during the years 1981–1983, and from April 1 to July 31, 1984. The total emergency department admissions for these three hospitals was 46,694 in 1982, the approximate mid-year period of the study.* We were able to estimate that this sampling scheme missed approximately 12% of all bicycle-related injuries during the study period; *ie,* those occurring during the winter months. This estimate was derived by reviewing data collected by the CPSC National Electronic Injury Surveillance System (NEISS, a computerized emergency department registry) at one of the city hospitals.

Emergency department log books were reviewed for any injury to the head with noted circumstances of injury suggesting that the incident occurred while riding a bicycle. At one hospital, all bicycle-related head injuries were identified through the NEISS computerized listings. The actual emergency department record and/or inpatient chart of each preliminary case was reviewed by an emergency department physician (EB or MB) to determine the type(s)

From the Section of Emergency Medicine, University of Wisconsin Hospital and Clinics, Madison (EB, MB); the Bureau of Community Health and Prevention, Wisconsin Division of Health, Madison (HW); World Health Organization (PR). Doctor Rattanassiri is currently in private practice in Thailand. Reprint requests to: Injury Control Unit, Room 325, Wisconsin Division of Health, PO Box 309, Madison, Wis 53701 (Attn: Hank Weiss, MPH); (phone: 608/267-7174). Copyright 1988 by the State Medical Society of Wisconsin.

*Data derived from the *1983 Wisconsin Hospital Directory* published by the Wisconsin Department of Health and Social Services and the Wisconsin Hospital Association.

and severity of head injury and to confirm bicycle involvement. Each case of bicycle-related head trauma was assigned to one or more of the following injury-type categories: (1) cranial vault fracture, (2) basilar skull fracture, (3) facial bone fracture, (4) concussion, (5) subdural hematoma, epidural hematoma, cerebral contusion or hemorrhage documented by computerized tomography [CT], or (6) soft tissue injury. The injury was classified as a concussion if there was reported loss of consciousness or changes in mental status such as disorientation or amnesia. Patients who sustained a more severe brain injury such as cerebral contusion or subdural hematoma were not classified as having a concomitant concussion.

Table 1—*Severity scale definitions*

Minor:	All isolated soft tissue injuries and tooth fractures.
Moderate:	All concussions, skull fractures, and facial fractures with Glasgow coma scale greater than 12; no evidence of brain injury on CT scan (if done).
Severe:	Cerebral injury with hospitalization greater than 48 hours and one of the following: abnormal CT scan, Glasgow coma scale of 9-12 on admission, or brain surgery.
Life-threatening:	Cerebral injury with Glasgow coma scale of 8 or lower on admission.

Table 2—*Age distribution of adult head injuries; 1981 to 1984 emergency department sample, Madison, Wisconsin*

Age Group	*Number*	*(%)*
18-22	79	(42)
23-27	51	(27)
28-32	22	(12)
33-37	13	(7)
38-42	10	(5)
43+	12	(6)
TOTAL	187	(100)

Table 3—*Distribution of the severity of adult bicycle-related head injuries (n=187); 1981 to 1984 emergency department sample, Madison, Wisconsin*

Severity Level	*Number of Cases*	*(%)*
Minor	119	(64)
Moderate	62	(33)
Severe	3	(2)
Life-threatening	3	(2)
TOTAL	187	(100)

The severity of head injury was classified according to the criteria in Table 1. All categories except "minor" utilize brain-injury criteria developed by Kraus et al.[5] In our study their criteria were modified to allow the inclusion of concussions and skull fractures in the "moderate" severity category even if the patient was not hospitalized. For our purposes, the term "brain injury" refers to those patients classified as having moderate, severe, or life-threatening head trauma, excluding those patients with isolated facial fractures.

A questionnaire was mailed to each injured bicyclist to elicit information regarding crash circumstances, rider characteristics, and helmet use. Data was elicited on: (1) helmet use at the time of injury, (2) circumstances of injury [bicycle-motor vehicle, bicycle-pedestrian, bicycle-fixed object, fall without collision, etc], (3) road conditions [wet or dry] and light conditions [day or night] at the time of injury, (4) type of bicycle [1-speed, 10-speed, etc], (5) frequency of riding [days/month], and (6) length of intended trip at the time of the injury.

Those people who did not respond to the questionnaire received a followup mailing or phone call. Case-finding techniques included efforts to determine current addresses through state motor-vehicle registration records, university alumni records, and telephone directories. Police records were used to gather information on the one fatality in the study.

The analysis gives the results of the entire study group and the brain-injured patients. P values below .05 (two-sided tests) were considered significant.

Table 4—*Brain-injured patients; distribution of injury types (n=59); 1981 to 1984 emergency department sample, Madison, Wisconsin*

Type of injury	*Number**	*(%)*
Basilar skull fracture	2	(3)
Facial bone fracture	3	(5)
Structural brain injury	4	(7)
Cranial vault fracture	6	(10)
Concussion	55	(93)
TOTAL	70	—

*Patients may have more than one injury type.

RESULTS. One-hundred and eighty seven (187) cases of bicycle-related head trauma were identified from the three hospitals during the study period. The mean age of the patients was 27 years. The highest frequency of cases was in the 18- to 22-year-old age group (Table 2). Males comprised 56% of all patients and the age distribution for each gender was similar.

The distribution of severity levels is shown in Table 3. The proportion of males and females was similar in the minor and moderate injury severity categories. All six patients with severe or life-threatening injuries were male. One hundred eighteen (63%) of 187 patients had injuries consisting of soft tissue contusions or lacerations.

Fifty-nine (32%) of the 187 patients had evidence of brain injury. The distribution of specific injury types in the brain-injured group is shown in Table 4. The four patients with structural brain injury had abnormalities documented by CT scan or autopsy. Three of these four patients sustained a life-threatening injury. Four out of six cranial vault fractures and the single basilar skull fracture occurred in patients with severe or life-threatening injury. Three (5%) of 55 patients with a concussion had an associated skull fracture.

A CT scan was done on 10 (17%) of the brain-injured patients. The scan was normal in six patients, but two of these patients were classified as having severe brain injury based on hospitalization greater than 48

hours and a Glasgow coma score of 9–12. Neither patient had a repeat CT scan and both were discharged from the hospital within one week of admission. All other cases with normal scans had a concussion and were classified in the moderate severity group. Abnormal scans included three cerebral contusions (one with mass effect) and one epidural hematoma. One patient had a compound skull fracture and intracerebral hemorrhage documented by autopsy. A facial bone fracture was present in three (5%) of 59 patients with brain injuries. All of these patients had an associated concussion and none had serious or life-threatening injuries.

Information from the followup questionnaire was collected from 104 (56%) of the 187 patients with head trauma. Among 59 patients with brain injury, thirty-two (54%) were followed up. The contacted and noncontacted groups were comparable in terms of age, gender, and proportion of severe or life-threatening injury. The lack of followup in 44% of the cases was mainly attributable to an inability to locate current addresses and phone numbers.

Overall, one of 104 patients with head trauma reported wearing a helmet at the time of injury. The one helmeted rider suffered a concussion. The mean frequency of bicycle use (days per month) was 21.9 (SD, 8.5) for the whole group and 22.6 (SD, 8.6) for the brain-injured patients. The mean distance for the trip in which the injury occurred was 10.5 miles (SD, 15.7) for the entire group and 16.7 miles (SD, 22.1) for the brain-injured patients. In the followup group, the injury was reported to occur during daylight hours under dry conditions by 79 of 100 (79%) respondents and 22 of the 30 (73%) patients with brain injury.

Table 5 shows the distribution of severity levels for each collision type. There was no significant difference in the proportion of minor versus more severe injuries for each collision type.

COMMENT. The results of this study show that transient loss of consciousness or amnesia occurs commonly among bicycle riders who require emergency department treatment for head trauma. In this series over 35% of patients sustained head trauma sufficient to cause loss of consciousness without major disability. The proportion of patients with brain injury in this series is similar to what was found in a one-year survey of injured bicyclists at the University Hospital of Umea, Sweden.[6] In their series of 447 injured bicycle riders, the head was the site most commonly injured and accounted for 34% of all injuries. Thirty percent (30%) of all patients with head trauma sustained a concussion or more severe brain injury. Other studies have demonstrated that head injury often occurs in association with bicycle falls or collisions, although functional disability was not assessed.[3,7] Similar results have been obtained in studies of bicycle injuries in children.[8,9]

Computerized tomographic (CT) studies were abnormal in four out of ten (40%) of those who were scanned, including one patient with a correctable neurosurgical lesion (epidural hematoma). Although this study was not designed to assess the indications for a CT scan, the high proportion of abnormal scans along with their overall infrequent use (17% of brain-injured patients) suggest that utilization was appropriate.

While the personal and societal consequences of severe brain injuries are obvious, there also is evidence to suggest that the large number of patients with concussions may have mild but persistent neurological deficits. One study of minor head injury, defined as a Glasgow coma score of 12–15 and less than 48 hours hospitalization, showed that 59% of the patients complained of memory deficits three months post-injury.[10] Sustained attention deficits were also noted on neuropsychological testing.

The followup questionnaire in our study failed to reveal any significant association between collision type and severity. Impact force and the severity of the resulting injury are dependent upon a combination of many factors including road speed, angle of impact, vertical height, and physical characteristics of the impacted surface. These variables could not be measured through our retrospective questionnaire. Findings from the followup questionnaire showed that most bicycle-related head injuries occur during daylight hours under dry conditions. This presumably is a reflection of greater bicycle use under favorable environmental conditions.

The followup indicated that bicycle-motor vehicle collisions were responsible for less than 20% of all brain injuries. While fatality studies have shown that bicycle and motor vehicle collisions are frequently associated with severe or fatal injuries[11], this study, based on emergency department records, points out that the majority of bicycle-related head trauma requiring hospital visits are associated with other types of collisions and falls. Further studies are needed to assess the incidence and severity of brain injury among both helmeted and unhelmeted bicycle riders and long-term cognitive impairment or neurological symptoms following mild to moderate closed head injury.

From the prevention perspective, a recently published epidemiological survey of helmet use and head injuries in a population of "cycling enthusiasts" reported a significant association between helmet use and reduced severity of head injury.[12] The authors further estimated "that the risk of death from head injury was considerably reduced for helmeted relative to unhelmeted bicyclists, depending upon helmet type."

Table 5—*Collision type for minor versus moderate and life-threatening injuries; 1981 to 1984 emergency department sample, Madison, Wisconsin*

Type of collision	Minor		Moderate and life-threatening		Total	
	#	(%)	#	(%)	#	(%)
Fall	19	(29)	12	(32)	31	(30)
Bike-motor vehicle	17	(26)	7	(19)	24	(24)
Bike-fixed object	11	(17)	9	(24)	20	(20)
Bike-bike	12	(18)	5	(14)	17	(17)
Bike-pedestrian	2	(3)	0	(0)	2	(2)
Did not remember	0	(0)	1	(3)	1	(1)
Other	4	(6)	3	(8)	7	(7)

Although other efficacy studies are rare or nonexistent,[9] the wisdom of helmet use is also supported by a wealth of biomechanics research,[13,14] and studies comparing the incidence and pattern of head injuries among helmeted moped, motorcycle, and competition bicyclists to unhelmeted bicycle riders.[15-20] In conclusion, properly designed and used bicycle helmets will reduce the risk of serious head injury among bicycle riders and should be recommended to and worn by all riders.

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CLINICAL CANCER: Number 21 of a series

New technologies in diagnosis and classification of malignancy

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THE DEVELOPMENT of new technologies has improved our ability to diagnose and classify many malignancies. This has been especially true in hematopoietic malignancies such as leukemia and lymphoma. Flow cytometry utilizing monoclonal antibodies, DNA probes, and chromosomal analysis (karyotype) are examples of technologic advances which have improved our diagnosis of hematopoietic malignancies and allowed us to classify them appropriately.

Twenty years ago all lymphocytes were the same, end-stage cells that were either mature (lymphocytic) or immature (lymphoblastic) based upon their morphology. Large cells found in lymphoproliferative disease were felt to be of nonlymphoid origin (reticuloendothelial) and, therefore, were called "histiocytic" or "reticulum cell sarcoma." New immunologic techniques developed over the next ten years defined subpopulations of lymphocytes which permitted a more precise classification of lymphoid neoplasms. In the late 1970s the new hybridoma technology allowed the production of large quantities of monoclonal antibodies. Most large cells were found to be transformed B lymphocytes of follicular center origin. Lymphomas and lymphocytic leukemias could be classified into stages of T or B cell maturation, based upon their immunophenotype.[1]

Until the late 1970s immunophenotyping of lymphocytes was dependent upon immunofluorescence of single cell suspensions which was very labor intensive. Flow cytometry using highly sophisticated equipment (expensive) is capable of determining surface markers present on hematopoietic malignancies and defining the immunophenotype. Material obtained from bone marrow aspiration is ideal because it is already in liquid single cell suspension, but lymph nodes may be teased and the cells suspended to be stained with the desired monoclonal antibody and subsequently reacted with a fluorescein marker which the machine can measure. Sophisticated computer programs can use cell size, complexity, DNA/RNA ratios, and other techniques to define cell populations. An immunophenotype on a cell suspension from a lymph node using

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flow cytometry can be accomplished in five minutes as opposed to many hours of work done manually by a laboratory technician. In addition, this technique may be more accurate because 5,000 to 10,000 cells may be counted for each monoclonal antibody used as opposed to perhaps 200 cells counted manually.

In addition, nearly all the antigens detected in cell suspension can be identified in tissue by recently developed immunoperoxidase techniques. Lymphoid antigens are very sensitive to fixation and paraffin embedding and, therefore, frozen tissue sections are frequently used when these diseases are suspected. Many other markers are capable of being detected in paraffin-embedded tissues and are useful for distinguishing carcinomas from lymphomas and diagnosing poorly-differentiated germ cell neoplasms, malignant melanoma, sarcomas, etc.

The hybridoma technology, which has produced a plethora of monoclonal antibodies, is capable of providing us with more information about these disorders, but is this information practical? With modern therapy it has been estimated that 50% of children with acute lymphocytic leukemia (ALL) can be cured.[2] T cell ALL has been associated with a poor prognosis in both children and adults. When such children are treated with drug regimens developed for non-T, non-B ALL, the prognosis is poor. When alternative drug regimens have been used, it has been suggested that these features lose their prognostic significance. In adults the five-year survival rate with any form of acute lymphocytic leukemia is less than 30%.[3] It is unclear whether intensive consolidation given in remission improves the prognosis in an adult with a poor prognosis immunophenotype, such as a T cell ALL. Many hematologists/oncologists believe that adults under age 40 with an HLA-matched sibling in first remission of ALL should be referred for bone marrow transplantation. Whether this technique of aggressive consolidation will prove to be more successful than chemotherapy is still controversial. However, if the treatment is the same whether an immunophenotype is defined or not, its value as a guideline to treatment loses significance.

Immunophenotype can be useful to distinguish myeloid from lymphoid leukemias in difficult cases.[1] The usual morphology and histochemistry is capable of diagnosing 90% of acute leukemias, but approximately 10% may be difficult and surface marker expression may be useful in this situation. Seven subtypes of acute nonlymphocytic leukemia (FAB classification) have been identified using morphology and histochemistry, and there have been many studies of the immunophenotype as defined by monoclonal antibodies to myeloid, lymphoid, and monocytic antigens. Although there has been considerable hetefogeneity in immunophenotype within the FAB classification, no critical difference dictating a change in treatment strategy has been identified. In 90% of acute leukemias an immunophenotype is superfluous. Since there is a marked difference in the currently used chemotherapeutic agents for lymphocytic as opposed to nonlymphocytic leukemia, an immunophenotype may be very useful when this diagnostic dilemma exists.

Another technique frequently used to evaluate patients with leukemia and lymphoma is the analysis of chromosomes (karyotype). Chromosome morphology or number is abnormal in 50%–100% of acute leukemias depending upon the institution.[4] Specific chromosomal abnormalities, such as the translocation between the 15th and 17th chromosomes occurs in acute progranulocytic leukemia. In patients with Burkitt's lymphoma or leukemia there is a specific translocation between the 8th and 14th chromosomes. The fact that translocations, deletions, additions, or extra chromosomes are found in the majority of patients has provided further support for the concept that acute leukemias are genetic disorders of hematopoietic cells. Unfortunately, in the majority of cases, the presence or absence of a chromosome abnormality rarely affects the choice of treatment utilized.

DNA probes and other techniques developed by molecular biologists have improved our ability to analyze genetic material to help solve clinical problems. When the morphological appearance of a lymph node or other tissue specimen is difficult to distinguish between a reactive process and a lymphoproliferative disease, an immunophenotype analysis by either flow cytometry or immunochemical techniques may demonstrate a single cell marker which is predominant. A dominant marker suggests a clonal process which is probably neoplastic. Many reactive lymphoid tissues contain numerous T cells and, therefore, a dominant surface marker such as $T4^+$ (helper/inducer T cells) or $T8^+$ (cytotoxic suppressor cells) marker may be either reactive or neoplastic. If markers of B cell immunophenotype are either lacking, or are not predominantly kappa or lambda, DNA probes for immunoglobulin gene arrangements or for the genes for T cell receptors can sometimes identify a clonal abnormality. Recent reports have suggested that immunoglobulin gene rearrangements can be detected in some benign lymphoepithelial lesions (Sjogren's syndrome),[5] thus emphasizing that even these molecular techniques are not fool proof in separating benign from malignant processes.

The theme that emerges from this discussion is that new and frequently expensive technologies can be very useful in the diagnosis and classification of malignancies as exemplified by the hematopoietic malignancies discussed. The expensive technologies of flow cytometry, immunohistochemistry, chromosomal analysis, and DNA probes need to be applied selectively to the appropriate clinical situation. In an era of cost-containment, expensive technology must

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Physicians are encouraged to contact the authors if they wish to discuss these topics further or obtain additional information. Comments or suggestions for topics would be welcome

be applied selectively and appropriately. When used in this fashion it will help us more accurately diagnose our patients, and prevent the most expensive mistake of all—the wrong diagnosis!

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Malignant cellular blue nevus: unusual case of a rare tumor

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ABSTRACT. *An unusual case of malignant cellular blue nevus is presented and the literature reviewed. A pigmented lesion was removed from a 62-year-old woman's scalp; histology showed an extremely cellular blue nevus. After wide excision she was disease-free for 11 years, then developed lymph node metastasis requiring two further operations. She was well for eight years, then presented with widespread visceral metastasis and died soon thereafter. The case illustrates malignant behavior despite a histologically benign-appearing primary lesion, and represents the longest reported "latent period" thus far seen in a malignant blue nevus. A review of reported cases as well as our own reveals that malignant blue nevi originate on the scalp with greater than twice (42% versus 17%) the frequency of cellular blue nevi.*

Key words: Malignant blue nevus; Cellular blue nevus

THE BLUE NEVUS is a common benign skin lesion. Less frequently seen is the cellular blue nevus, which occasionally gives rise to isolated nodal metastases.[1,2] The malignant blue nevus is uncommon; there have been less than 20 cases reported in the English literature.[3-13] Several authors have delineated histologic criteria to attempt to differentiate malignant blue nevi from benign cellular blue nevi. These criteria include necrosis, mitotic figures, pleomorphism, enlarged hyperchromatic nuclei, vacuolization, and questionably the presence of giant cells.[1,2,4,8,9,14,15]

We report a case of a malignant blue nevus with a latent period approaching 20 years, and with clinical behavior contrary to that predicted by histologic criteria.

Case report. In July 1966 a 62-year-old white female presented with a pigmented lesion on the frontoparietal scalp, present for at least four years. Biopsy was interpreted as cellular blue nevus and complete excision was performed. The diagnosis of malignant blue nevus was suggested and the patient referred to our clinic for further care. Review of the specimen revealed an extremely cellular blue nevus (Fig 1). The lesion was sharply defined with a lobulated contour. The cellular population was predominantly spindle cells which varied in the degree of cellular activity and contained irregular areas of heavy cytoplasmic melanin pigmentation. The spindle cells had oval nuclei with an evenly staining chromatin network. The irregular areas showed larger nuclei with nucleoli and an occasional mitosis. There was no necrosis. The epidermis was thin, and the basal layer was well defined with no evidence of melanotic dysplastic changes. Microscopically the lesion extended to the deep margin of excision.

Although this extremely cellular blue nevus was not felt to definitely represent a malignancy, wider excision seemed prudent. The scar and surrounding skin was excised down to galea and the defect closed with a skin graft. Histology revealed no evidence of residual tumor.

Eleven years later, in January 1977, the patient presented with a 6 cm enlarged lymph node in the right posterior cervical triangle. Needle biopsy showed skeletal muscle with melanin pigment present. A modified radical neck dissection was performed. A 5 cm soft black mass was adherent to the proximal portion of the sternocleidomastoid muscle. Histology showed a lymph node largely replaced by tumor (Fig 2) consisting of spindle-shaped cells. Many cells were heavily laden with pigment with nuclei showing some pleomorphism and often containing prominent nucleoli. Mitoses were not observed, but there were extensive areas of necrosis. With histologic evidence of metastatic tumor in regional lymph nodes, it became clear that what was originally felt to be an extremely cellular blue nevus actually represented a malignant cellular blue nevus.

Three months later, because of a right preauricular fullness, a superficial parotidectomy was done. Histology showed chronic inflammation in the parotid gland, several normal lymph nodes, and a 1.8 cm black lymph node nearly replaced by tumor. This tumor consisted of interlacing bundles of fusiform melanocytic cells with areas of necrosis and infrequent mitoses.

In May 1985 the patient (now 81 years of age) returned with weight

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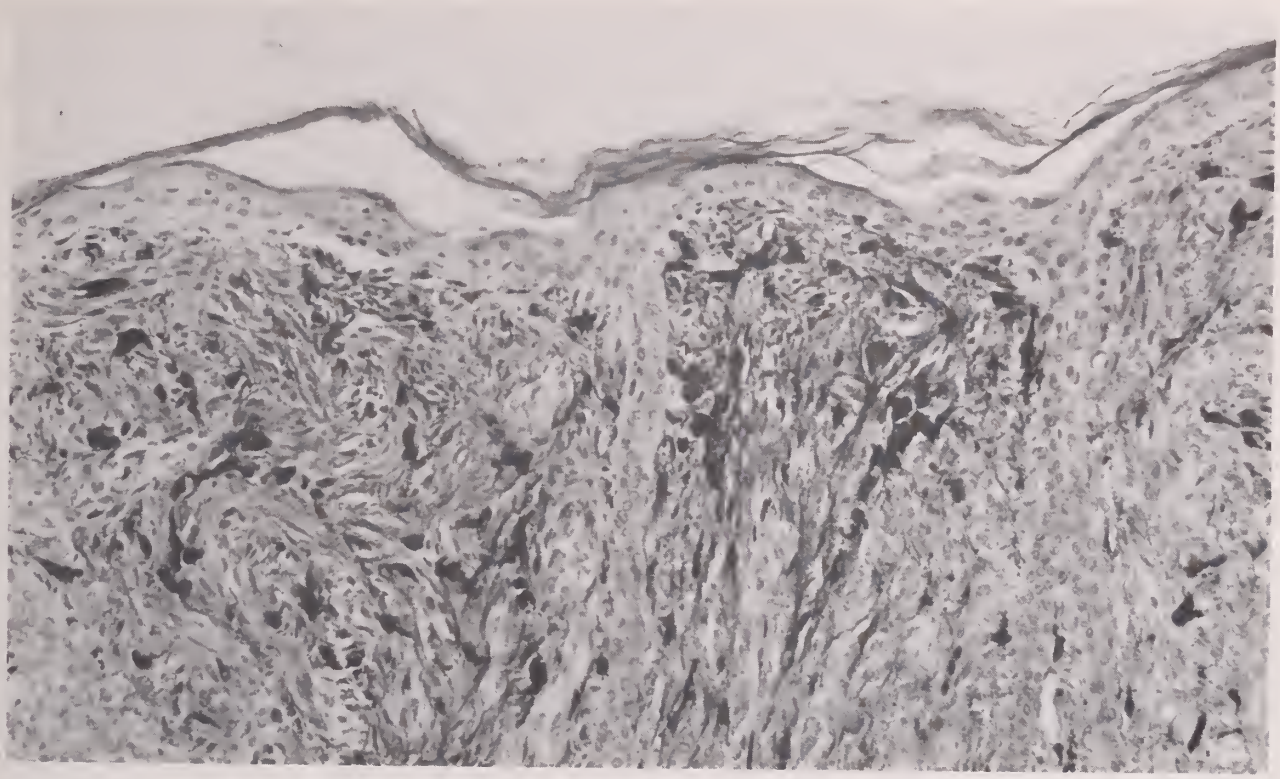
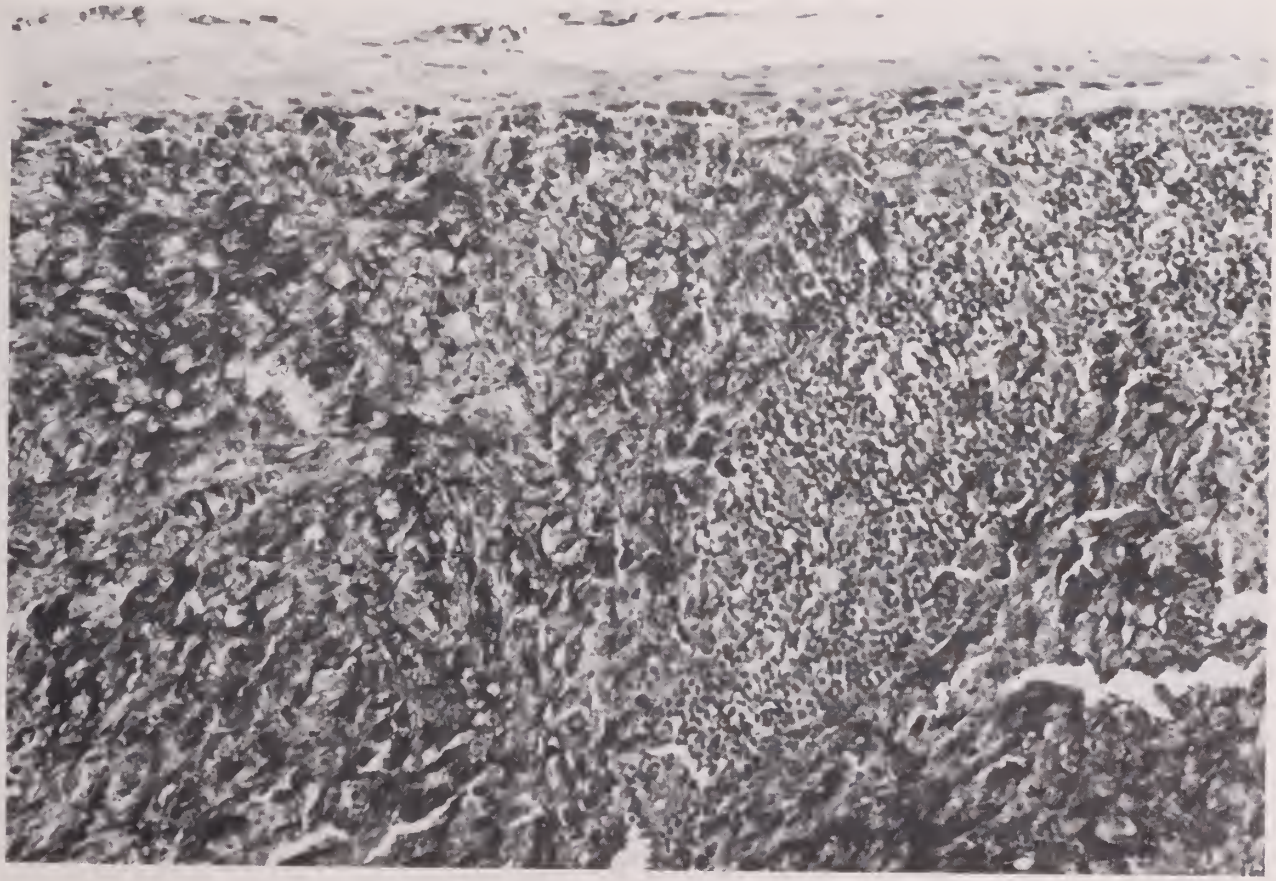


FIGURE 1—*Extremely cellular blue nevus (mag 100×).*

FIGURE 2—*Lymph node largely replaced by tumor (mag 100×).*



loss and anorexia. Evaluation revealed a noncalcified nodule in the upper left lung, a 12.4 by 7.6 cm target lesion in the right lobe of the liver, and a 5 cm mass in the left adrenal gland. Esophagogastroduodenoscopy showed an ulcerated 1.5 by 2 cm fundal mass, biopsies showed only inflamed mucosa. Percutaneous ultrasound guided liver biopsy obtained cells which stained positive for melanin. As there were no signs of another primary tumor, diagnosis at this point was malignant cellular blue nevus with metastasis to lung, liver, adrenal gland, and gastrointestinal tract. Chemotherapy was felt to be of little value; the patient was given supportive care and died soon thereafter. Permission for autopsy was denied.

DISCUSSION. This case is unusual in two aspects. First, it is the second reported case where careful histologic examination of the primary lesion appeared to be a benign cellular blue nevus and the subsequent course of the lesion proved it to be malignant. Secondly is the time from resection of the primary lesion to the demonstration of visceral metastases: 19 years. This represents the longest reported "latent period" thus far noted in a malignant blue nevus.

The primary lesion in our patient appeared to be a benign cellular blue nevus. It exhibited no necrosis, few mitoses, no vacuolization, and had only minimal pleomorphism. Of the criteria for malignancy mentioned in the cases reviewed, necrosis appears to be the most definite. In lymph nodes the presence of tumor necrosis and the tendency towards replacement of lymph node by tumor indicates malignancy versus "benign metastases."[1,2,4]

Cellular blue nevi are particularly common on the dorsa of the hands and feet, in the lumbosacral region, and on the buttocks.[4,6,16] Seventeen percent (17%) occur on the scalp.[1,10] The distribution of malignant blue nevi has been reported to parallel that of cellular blue nevi.[4,6] Our review of the reported cases as well as our own, however, reveals that 42% (8/19) of malignant blue nevi originated on the scalp.

Lambert and Brodkin recently advised conservative treatment when faced with cellular blue nevi metastatic to lymph nodes in the absence of clear evidence of malignancy[2] and presented a patient who exhibited no evidence of disease ten years following aggressive resection with prophylactic regional lymph node dissection. The patient described by Kwittken and Negri had a lesion with similar histology and died of widespread metastatic disease 7.5 years following incomplete surgical excision of the primary tumor.[7] Our patient died with widely metastatic disease despite aggressive surgery; and while the microscopic appearance of the tumor in her lymph nodes was more malignant-appearing than the case described by Lambert and Brodkin, the difference in clinical course would be difficult to predict without lymph node histology.

CONCLUSIONS. The clinical behavior of a cellular blue nevus can be malignant despite a histologically benign-appearing primary lesion, and it may be more accurately predicted based on the microscopic appearance of lymph node metastases. The time period from appearance of the primary skin lesion to visceral metastases can be greater than 20 years necessitating long-term follow-up. Malignant blue nevi originate on the scalp with two and one-half times the frequency of benign cellular blue nevi.

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Disinfecting scuba diving equipment

The Questions and Answers section of Dec 27 *Journal of the American Medical Association* discusses whether disease—including human immunodeficiency virus (HIV)—can be transmitted through scuba diving equipment, such as when "buddy breathing" is practiced during scuba lessons. Walter W. Bond, MS, of the Centers for Disease Control (CDC), Atlanta, says the CDC has received an increasing number of queries in recent years about this issue (eg, infection through "dirty" scuba mouthpieces). Despite unpublished anecdotal reports, scuba equipment "has never been documented as responsible for an outbreak or even a single case of bacterial, fungal, or viral disease, including HIV infection," he says. While sharing contaminated equipment may represent a hypothetical HIV transmission risk, "the likelihood . . . is remote," he adds. To eliminate even remote risk, he suggests a second regulator/mouthpiece (required in certified scuba training) and mouthpiece disinfection.—*AMA Brief Report*■

Before prescribing, see complete prescribing information in SK&F LAB CO. literature or PDR. The following is a brief summary.

Contraindications: *There are no known contraindications to the use of 'Tagamet'.*

Precautions: *While a weak antiandrogenic effect has been demonstrated in animals, 'Tagamet' has been shown to have no effect on spermatogenesis, sperm count, motility, morphology or in vitro fertilizing capacity in humans.*

In a 24-month toxicity study in rats at dose levels approximately 9 to 56 times the recommended human dose, benign Leydig cell tumors were seen. These were common in both the treated and control groups, and the incidence became significantly higher only in the aged rats receiving 'Tagamet'.

Rare instances of cardiac arrhythmias and hypotension have been reported following the rapid administration of 'Tagamet' HCl (brand of cimetidine hydrochloride) injection by intravenous bolus.

Symptomatic response to 'Tagamet' therapy does not preclude the presence of a gastric malignancy. There have been rare reports of transient healing of gastric ulcers despite subsequently documented malignancy.

Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chlordiazepoxide, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.), demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. (Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.)

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

Adverse Reactions: *Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states (e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation), predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving 'Tagamet', particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in 'Tagamet'-treated patients (approximately 1 per 100,000 patients), including agranulocytosis (approximately 3 per million patients), have been reported, including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia (approximately 3 per million patients) and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly unlikely. A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving 'Tagamet' has been reported.*

How Supplied: Tablets: *200 mg. tablets in bottles of 100; 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only); 400 mg. tablets in bottles of 60 and Single Unit Packages of 100 (intended for institutional use only), and 800 mg. Tiltab® tablets in bottles of 30 and Single Unit Packages of 100 (intended for institutional use only).*

Liquid: *300 mg./5 ml., in 8 fl. oz. (237 ml.) amber glass bottles and in single-dose units (300 mg./5 ml.), in packages of 10 (intended for institutional use only).*

Injection:
Vials: *300 mg./2 ml. in single-dose vials, in packages of 10 and 30, and in 8 ml. multiple-dose vials, in packages of 10 and 25.*

Prefilled Syringes: *300 mg./2 ml. in single-dose prefilled disposable syringes.*

Plastic Containers: *300 mg. in 50 ml. of 0.9% Sodium Chloride in single-dose plastic containers, in packages of 4 units. No preservative has been added.*

ADD-Vantage®* Vials: *300 mg./2 ml. in single-dose ADD-Vantage® Vials, in packages of 25.*

Exposure of the premixed product to excessive heat should be avoided. It is recommended the product be stored at controlled room temperature. Brief exposure up to 40°C does not adversely affect the premixed product.

'Tagamet' HCl (brand of cimetidine hydrochloride) injection premixed in single-dose plastic containers is manufactured for SK&F Lab Co. by Travenol Laboratories, Inc., Deerfield, IL 60015.

** ADD-Vantage® is a trademark of Abbott Laboratories.*

BRS-TG:L738 *Date of issuance Apr. 1987*

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In peptic ulcer:

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brand of *cimetidine*
First to Heal

You'll both feel good about it.

RESULTS

This space contributed as a public service.

A defense against cancer can be cooked up in your kitchen.

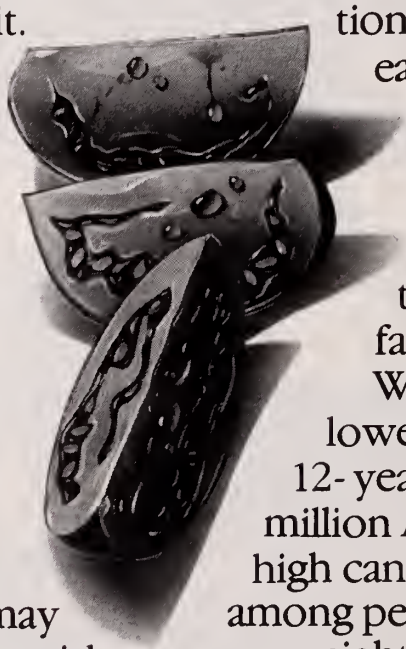
Fruits, vegetables, and whole-grain cereals such as oatmeal, bran and wheat may help lower the risk of colorectal cancer.

Foods high in fats, salt- or nitrite-cured foods like ham, and

fish and types of sausages smoked by traditional methods should be eaten in moderation.

There is evidence that diet and cancer are related. Some foods may promote cancer, while others may protect you from it.

Foods related to lowering the risk of cancer of the larynx and esophagus all have high amounts of carotene, a form of Vitamin A which is in cantaloupes, peaches, broccoli, spinach, all dark green leafy vegetables, sweet potatoes, carrots, pumpkin, winter squash and tomatoes, citrus fruits and brussels sprouts.



Be moderate in consumption of alcohol also.

A good rule of thumb is cut down on fat and don't be fat.

Weight reduction may lower cancer risk. Our 12-year study of nearly a million Americans uncovered high cancer risks particularly among people 40% or more overweight.

Foods that may help reduce the risk of gastrointestinal and respiratory tract cancer are cabbage, broccoli, brussels sprouts, kohlrabi, cauliflower.

Now, more than ever, we know you can cook up your own defense against cancer. So eat healthy and be healthy.

No one faces cancer alone.

AMERICAN CANCER SOCIETY®

The benefit of antianginal protection plus safety...

CARDIZEM®: A FULLER LIFE

diltiazem HCl/Marion

- ***A remarkable safety profile***[1-6]
  The low incidence of side effects with Cardizem allows patients to feel better.
- ***Protection against angina attacks***[1,5,7-9]
  The predictable efficacy of Cardizem in stable exertional and vasospastic angina allows patients to do more.*
- ***A decrease in myocardial oxygen demand***
  Resulting from a lowered heart rate-blood pressure product.[5]
- ***Compatible with other antianginals***[6†]
- ***Safe in angina with coexisting hypertension, COPD, asthma, or PVD***[1,3,5,6]

60 mg 90/120 mg GREATER DOSAGE FLEXIBILITY

*CARDIZEM® (diltiazem HCl) is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents

†See Warnings and Precautions.

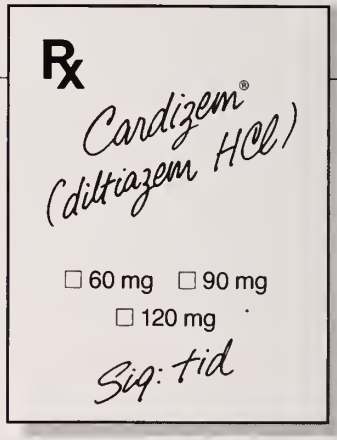
Please see brief summary of prescribing information on the next page.

0453S7

CARDIZEM® ANTIANGINAL PROTECTION PLUS SAFETY

diltiazem HCl/Marion

Usual maintenance dosage range: 180-360 mg/day



Brief Summary
Professional Use Information

CARDIZEM®
(diltiazem HCl) 30 mg, 60 mg, 90 mg, and 120 mg Tablets

CONTRAINDICATIONS
CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. ***Cardiac Conduction.*** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. ***Congestive Heart Failure.*** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).*
   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS
General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women, therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS
Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.*
Gastrointestinal:	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.*
Dermatologic:	*Petechiae, pruritus, photosensitivity, urticaria.*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

Issued 9/'86

See complete Professional Use Information before prescribing.

References: ***1.*** *Schroeder JS: Mod Med 1982;50(Sept):94-116.* ***2.*** *Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39.* ***3.*** *O'Rourke RA: Am J Cardiol 1985;56:34H-40H.* ***4.*** *McCall D, Walsh RA, Frahlich ED, et al: Curr Probl Cardiol 1985;10(8):6-80.* ***5.*** *Fishman WH, Charlap S, Goldberger J, et al: Am J Cardiol 1985;56:41H-46H.* ***6.*** *Shapiro W: Consultant 1984,24(Dec):150-159.* ***7.*** *O'Hara MJ, Khurmi NS, Bawles MJ, et al: Am J Cardiol 1984,54:477-481.* ***8.*** *Strauss WE, McIntyre KM, Parisi AF, et al: Am J Cardiol 1982;49:560-566.* ***9.*** *Feldman RL, Pepine CJ, Whittle J, et al: Am J Cardiol 1982;49:554-559.*

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Physicians are encouraged to submit brief essays on any subject that reflects an in-depth perspective. Essays will be subject to the usual approval by the Editorial Board

Jesse's escape

Douglas S Diekema, MD
Madison, Wisconsin

I MET JESSE on the first day of my internship. A 17-year-old who had never before left home, he came amidst the chaos I faced that day. His local doctor, alarmed by Jesse's enormously enlarged neck and relentlessly sore throat, had rushed him to our high-tech medical center for further evaluation. Traveling the 110 miles by ambulance, Jesse entered our world.

Jesse came alone, and he reacted as a foreigner might to a new land. The member of a local street gang, his sense of security depended upon the presence of his "brothers." But Jesse now found himself alone—the security of his life shattered by circumstances over which he had no control. The frightening sounds and flashing lights of the hospital had replaced the streets which he knew so well. The alarming progression of his illness and its accompanying pain steadily sapped his physical strength. His parents, unable to afford the trip to our hospital, had remained behind. Isolated from nearly everything and everyone he knew, Jesse's usual sense of invulnerability gave way to fear.

More than anything else, Jesse dreaded the visits of the phlebotomist, and the blood taken from him soon confirmed the diagnosis we feared. Jesse was harboring an aggressive variant of chronic myelogenous leukemia. In those few days it took to confirm the diagnosis, Jesse seemed to wither before my eyes. The morning after his arrival, he'd stopped me on rounds to see if I could find him another box of frosted flakes. His appetite hadn't been satisfied by the pancakes and eggs he'd already consumed. Yet now, only two days later, the message of Jesse's diagnosis was followed by the news that he was refusing to eat. His cancer was advancing rapidly, and even the morphine drip I'd ordered failed to relieve his painful throat. The various members of the oncology team quickly readied themselves for the first round of a chemotherapy assault. Meanwhile, I tended to Jesse's simple daily needs, hoping to bring some comfort to this weary, frightened, and lonely boy.

He wanted to see his parents. He also wanted to go home. "That's not possible," I mumbled, trying to explain this new enemy we were preparing to fight. But Jesse's terror continued, and finding himself unable to bear the prospect of a third night, he pulled out his intravenous needle and charged out of his room. He needed an escape route—any escape route—and as he searched, a crowd of pursuers closed in. Facing this formidable group of nurses, medical students, and residents he demanded that they allow him to go home. Then, like a cornered rabbit, he bolted for the nearest door.

Later that evening we found him crouching in a stairwell, blood still oozing from his intravenous site as he quietly trembled and sobbed. His attempted escape had been turned back by the maze we called a hospital. We gently led him back to his room and explained that we couldn't allow him to go—for his own good. And we believed our words, even if he didn't.

Jesse resigned himself to the hospital routine after that night. The enormous mass residing in his neck regressed only a little with the first wave of chemotherapy. We followed this closely with a second course, still hoping and praying that we could eradicate the resilient enemy from Jesse's body. But the poison of the chemotherapy soon took its toll. He suffered more each day. The mucositis we had induced only exacerbated the pain in his throat. With a renewed sense of urgency, I directed my efforts toward finding the resources that would allow a visit from his family. After several aborted attempts, we finally made the arrangements. They could only stay a day, but we welcomed their suggestion that Jesse's younger brother remain with us. Even though the pain continued and the cancer pressed onward, Jesse seemed comforted by his brother's presence. The nights seemed quieter. Where before only Jesse had slept, now two boys huddled closely together.

Six weeks have passed since Jesse first tried to elude our grasp. A week ago we moved him to the intensive care unit. His cancer has proved unresponsive to our magic bullets. Jesse became hypotensive and septic in spite of our efforts. He now exists passively, unable to run from us. A ventilator breathes for him. Cardiostimulatory drugs drive his failing heart. We dialyze him daily to replace the functions of a liver and kidneys which have called an end to their work. Yet the ICU staff refuses to admit that Jesse may have eluded their grasp. Our oncologists insist that if they can only keep him alive, perhaps a bone marrow transplant might save him. And Jesse keeps his silence, allowing the technology which surrounds him to drive his physiologic functions. On that evening six weeks ago, we turned back Jesse's attempt to escape our medical intervention. Earlier this week we ignored his anguished request to be allowed to die. Now it seems that Jesse has found another way to elude our efforts, and he seems to have outrun us this time. Perhaps tomorrow his driven heart will slip silently into the still night, eluding even the relentless pursuit of the ICU staff. Or perhaps the lords of the ICU will admit their defeat and allow him to go quietly on his way without a struggle.■

From the Department of Pediatrics, University of Wisconsin Hospital and Clinics, Madison. Reprint requests to: Douglas S Diekema, MD, Dept of Pediatrics, 600 Highland Ave, Madison, Wis 53792. Copyright 1988 by the State Medical Society of Wisconsin.

Past President's Task Force to review liability issue

Following a meeting of the Wisconsin Society of Obstetrics and Gynecology at which Richard G Roberts, MD, Vice Chairman of the SMS Liability Committee, and Herbert F Sandmire, MD of the Coalition for Fairness in Medical Litigation, made presentations addressing their stance on medical liability issues and tort reform, the Board of Directors of the OB-GYN Society requested that SMS review proposals that encourage modification of both the old Patients Compensation Panels and the new Mediation Panel System.

At a special meeting on December 16, 1987, the SMS Executive Committee determined that this request be forwarded to a special task force of past presidents of the State Medical Society. This task force was created to review all relevant data regarding the issue and to hear presentations from both Doctor Sandmire and representatives of the SMS Liability Committee. The Executive Committee accepted the recommendation of Thomas L Adams, Secretary-General Manager of SMS, that the immediate seven past presidents of the Society serve on this special task force.

The task force is chaired by *Russell F Lewis,* MD (OB-GYN), formerly of Marshfield, currently residing in Madison. Other members of the task force are *Albert J Motzel,* MD (General Surgery), Waukesha; *Gerald C Kempthorne,* MD (Family Practice), Spring Green; *Timothy T Flaherty,* MD (Radiology), Neenah; *Chesley P Erwin,* MD (Pathology), Milwaukee; *John K Scott,* MD (Otolaryngology), Madison; and *John P Mullooly* (Internal Medicine), MD, Milwaukee. The task force was to meet January 11 at SMS offices in Madison. Representatives of all specialty societies and sections were invited to attend and observe the deliberations of the task force. In addition, any interested member of the Society was welcome to observe the proceedings.

The SMS Executive Committee notes that this special task force is comprised of physician leaders in Wisconsin who all have been elected by the SMS House of Delegates to serve as president of SMS, and that they offer a unique ability to analyze the situation and make recommendations to the SMS Board of Directors.■

AMA Physician's Recognition Award Recipients

LISTED BELOW are those physicians in Wisconsin who have earned the AMA Physician's Recognition Award in recent months. The State Medical Society of Wisconsin congratulates these physicians who have distinguished themselves and their profession by their commitment to continuing education:

NOVEMBER 1987

*Aaberg, Thomas M, Milwaukee
*Erchurl, James W, Appleton
*Frazin, Lawrence J, Milwaukee
*Geldner, Michael M, Neenah
Grosshans, James T, Wautoma
Henry, Catherine G, Wisconsin Rapids
*Macasaet, Rolando A, Viroqua
*Myers, Franklin L, Madison
*Olson, Carl E, Milwaukee
*Redfern, Sallie, Oshkosh
*Samadani, Ayaz M, Beaver Dam
*Sinclair, Eugene P, Elm Grove
Storm, Frederick K, Middleton
*Tibbetts, Palmer G, Milwaukee
*Zastrow, Raymond C, Milwaukee

*Members of the State Medical Society of Wisconsin ■

CES Foundation Board met December 2

At its meeting December 2, 1987 in Madison, the Board of Directors of the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin created the Reginald Jackson, Sr, MD loan-scholarship program. It was made possible by a substantial bequest from the estate of Reginald Jackson, Jr, MD. The new program, established by the Foundation's Board, will provide an annual award of $20,000 for a needy medical student. Each medical school in Wisconsin will be asked to submit candidates for consideration as recipients. A deserving second-year medical student will be chosen to receive the loan-scholarship, payable in two installments of $10,000; the first at the beginning of his/her junior year, with the same amount to be awarded at the beginning of the student's senior year. The program is designed so that the loan is forgiven if the student receives an MD degree.

The Board of Directors of the Foundation also agreed to accept and manage the Earl R Thayer Lecture Fund. The fund was established by the Wisconsin Association of Senior

continued next page

SMS opposes HCFA mortality data release

Early in December SMS issued a strongly worded statement objecting to the Health Care Financing Administration's (HCFA) release of national hospital mortality data. The data compares death rates in all US hospitals treating Medicare patients in 1986 to "expected" death rates for 16 separate illness categories projected by a computer model.

Commenting on the data release, Thomas L Adams, Secretary-General Manager of the State Medical Society, said, "We in Wisconsin share the concerns of the American Medical Association regarding the methods used by HCFA to produce the data to be published, as well as the numerous technical flaws in the methodology, and the nebulous relationship between mortality statistics and the overall quality of care delivered by the hospitals in question." Adams went on to note that, "the AMA has encouraged HCFA to back up its claim that the data are useful to physicians, hospitals, and consumers by providing explicit guidelines, examples, and instructions on how to use the data; but HCFA has responded to this request, in only a very limited fashion, leaving many critical questions unanswered."

Mr Adams went on to say that, "given the limitations of the data and the methodology, there is simply no way that the data can be interpreted or deciphered to measure hospital quality. The physicians of Wisconsin are concerned that the public can be misled by these or future numbers if they mistakenly believe that the data provided can assist them in choosing the highest quality hospitals and avoid low quality hospitals."

According to Mr Adams, "Wisconsin physicians and the hospitals in which they practice have an excellent working relationship through the hospital medical staff organization and peer review functions to assure that quality of care is available throughout the state. The State Medical Society of Wisconsin and the Wisconsin Hospital Association have a continued commitment to assuring Wisconsin patients high quality medical care. The State Medical Society of Wisconsin and the Wisconsin Hospital Association are already on record as supporting Governor Tommy Thompson's recommendation that an Office of Health Care Information be established in the state. This Office of Health Care Information would be capable of developing a more sophisticated data system at the state level, using more timely and more reliable data from Wisconsin hospitals."■

CES FOUNDATION continued

Physicians in honor of Earl R Thayer, former Secretary-General Manager of SMS. The fund will be used to support scientific lectures in the State of Wisconsin, primarily at the SMS Annual Meeting.

In other actions, the CESF Board: began development of an awards program for the Foundation; discussed the results of a recent benefit auction and sale for the Foundation's AIDS education efforts which raised approximately $5,000; updated and increased thresholds in the Foundation's student loan program; contributed $1,000 from the Clara Joss Trust Fund to the University of Wisconsin Chapter of Doctors Ought to Care to assist them in a public service project; and granted requests from the Drug Free Youth program and the Prairie Living Center in Prairie du Chien for $100 donations, and contributed $2,000 to the SMS's Wisconsin Workshop on Health.■

SMS pursues liability clarification from UW

In a Nov 10, 1987 letter to Arnold L Brown, MD, Dean of the University of Wisconsin Medical School, SMS Secretary-General Manager Thomas L Adams called upon the Medical School to clarify confusion surrounding the potential liability of private practice physicians who volunteer to serve as faculty members or preceptors for UW Medical School students and residents.

The issue came to a head when a physician in the Chippewa Valley area of Wisconsin was sued for negligence which allegedly occurred in relation to a procedure being performed with a UW medical student. This physician, along with many others throughout the state who serve as preceptors or faculty members, had assumed that in the event of such a suit they would fall under, and be covered by state statutes limiting liability for state employees and agents.

However, based on correspondence received from Dean Brown it appears that the state will not cover suits that arise from patient care activities performed by preceptors or clinical faculty. According to Brown, preceptors and clinical faculty who

continued next page

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WHAT'S THE REAL "BOTTOM LINE?"

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SOCIOECONOMICS

Are the Mediation Panels working?

The State Medical Society has received many comments and expressions of concern about the new Medical Mediation Panels. They can be lumped together into one question: Are the Mediation Panels working? The SMS decided to ask an expert, Randy Sproule, administrator of the Medical Mediation Panels in the Office of State Courts. The following article is Mr Sproule's response to the question.

Mr Sproule was the last administrator of the now-defunct Patients Compensation Panel system and has headed the Mediation Panels since their inception on Sept 1, 1986. He has kept close track of the cases that have been resolved and has polled defendants, plaintiffs, and panel participants. This article discusses this information and Mr Sproule's perceptions of the Mediation Panels.

* * *

THE ONE QUESTION I have been asked on a daily basis for the past 12 months is: Are the Mediation Panels working? The question is subjective in nature and the answer depends, in part, upon one's expectations of the Panels.

More than 50% of all medical malpractice claims are resolved without payment to the claimant. A significant portion of the medical malpractice insurance premium dollar is nevertheless attributable to the cost of defending those claims. The Mediation Panels were designed to help identify those claims as early in the proceedings as possible, thereby reducing the defense costs. Additionally, the Panels were designed to assist in the resolution of the less complex, relatively low damage claims. The traditional circuit court process has proved to be an expensive, time-consuming procedure for resolving those claims. An analysis of the first 200 cases that have proceeded through mediation provides objective data upon which to determine whether the Panels are accomplishing those goals.

Nine percent (9%) of the cases that have proceeded through mediation have settled at or shortly after as a result of mediation. The majority of those cases, as expected, were settled for $10,000 or less. Although those cases probably would have settled eventually without mediation, they were settled more expeditiously and at a lower cost than they would have if the parties had been required to proceed through the traditional circuit court process. Defense counsel has indicated that a number of additional relatively low damage claims would have settled but for the requirement that all settlements be reported to the State Medical Examining Board by the Office of the Commissioner of Insurance.

In an additional 12% of the cases, the matter was not settled at mediation but has not been filed in circuit court and the statute of limitations has expired. Because the statute of limitations has expired, those claims are now forever barred. Those cases were, in effect, resolved at mediation arguably because the claimant ac-

continued next page

ORGANIZATIONAL/LIABILITY CLARIFICATION continued

provide medical student or resident training in the context of their own medical practice and who carry their own liability insurance should rely on that insurance to cover them for claims and suits. Dean Brown went on to say that a defense, but not indemnification, will be offered to the preceptor's carrier in cases where the preceptor is sued for negligent supervision. He noted that medical students and residents will be defended by the Attorney General and indemnified by the state in all claims and suits arising out of their role in the UW Medical School's sponsored training programs.

Mr Adams expressed the fears of many SMS physician members around the state who are understandably concerned after learning that all risks of defending against or paying a malpractice claim rests with the individual's physician and not with the state, even if the claim is founded upon the physician's acts or admissions in his or her teaching role.

Noting that the involvement of volunteer preceptors and faculty is clearly essential for the continuation of a strong teaching program, Mr Adams stated "it seems unfair to leave the physician and the physician's insurer in the position of being the deep pocket in any negligence action. I believe this is a problem which we must attempt to resolve and I hope that we can work together to resolve it, with new legislation as necessary." In his letter to Secretary-General Manager Adams, Dean Brown indicated that the volunteer faculty is extremely important to the school's educational programs and that the Medical School continues to study the problem and has pledged to contact SMS again with additional proposals.■

continued

cepted the impartial evaluation of the mediators that the medical treatment did not deviate from the appropriate standard of care.

In yet an additional 12% of the cases, the matter was not settled at mediation and has not been filed in circuit court but the statute of limitations has not expired. Some of those cases will no doubt be filed in circuit court prior to the expiration of the statute of limitations, some will not. Assuming that half of those cases will not be filed, the Mediation Panels have "resolved" 27% (9% + 12% + 6%) of the cases that have proceeded through mediation.

The mere fact that a case was pursued in circuit court after the mediation session does not necessarily mean that the session was unproductive. In 39% of the cases that were pursued in circuit court after mediation the parties have indicated that the mediation served a constructive purpose. The mediation may have resulted in the dismissal of one or more of the parties, it may have narrowed or clarified the issues, or it may have brought the parties closer than they were prior to mediation, thus enhancing the prospects of, and perhaps expediting, a future settlement.

Are the Mediation Panels working? 27% of the cases that have proceeded through mediation have been resolved within 90 days and without court action. Mediation has served a constructive purpose in 39% of the remaining cases. The Mediation Panels are not the panacea for the problem of spiraling medical malpractice insurance premiums. Indeed, there is no singular panacea. Nor is the mediation format or the administration thereof without flaws. The statistics show, however, that the Panels are, for the most part, accomplishing the goals for which they were created. The next step is to address those cases and problems which the Panels were not designed to address.

* * *

Physicians wishing further information on the Mediation Panels should contact either Kit Nimtz, policy analyst in the SMS Division of Medical Policy and Practice (phone 608/257-6781 or 1-800-362-9080), or Randy Sproule in the Office of State Courts, 110 E Main St, Room 320, Madison, Wis 53703, or phone 608/266-7711.■

Clarification on AIDS story

The December 1987 issue of the *Wisconsin Medical Journal* carried a story detailing the American Medical Association's recent policy statement on physician rights and responsibilities in treating AIDS patients.

Specifically, the story listed the AMA's position regarding the reporting of seropositive individuals by stating "Where there is no statute that mandates or prohibits the reporting of seropositive individuals to public health authorities and a physician knows that a seropositive individual is endangering a third party, the physician should: (1) attempt to persuade the infected patient to cease endangering the third party; (2) if persuasion fails, notify authorities, and (3) if the authorities take no action, notify the endangered third party."

SMS members should be aware, however, that Wisconsin has a very comprehensive statute regarding AIDS and HIV antibody testing and reporting which allows physicians to disclose the results of tests for the presence of an antibody to HIV to the State Epidemiologist or his or her designee for the purpose of providing epidemiologic surveillance or investigation or control of communicable disease. Wisconsin statutes also provide for civil or criminal penalties against individuals who disclose these test results in violation of state statutes.

For a complete explanation of AIDS and HIV antibody testing and reporting requirements in *Wisconsin Statutes,* members are encouraged to review pages 61-63 of the June 1987 issue of the *Wisconsin Medical Journal.*■

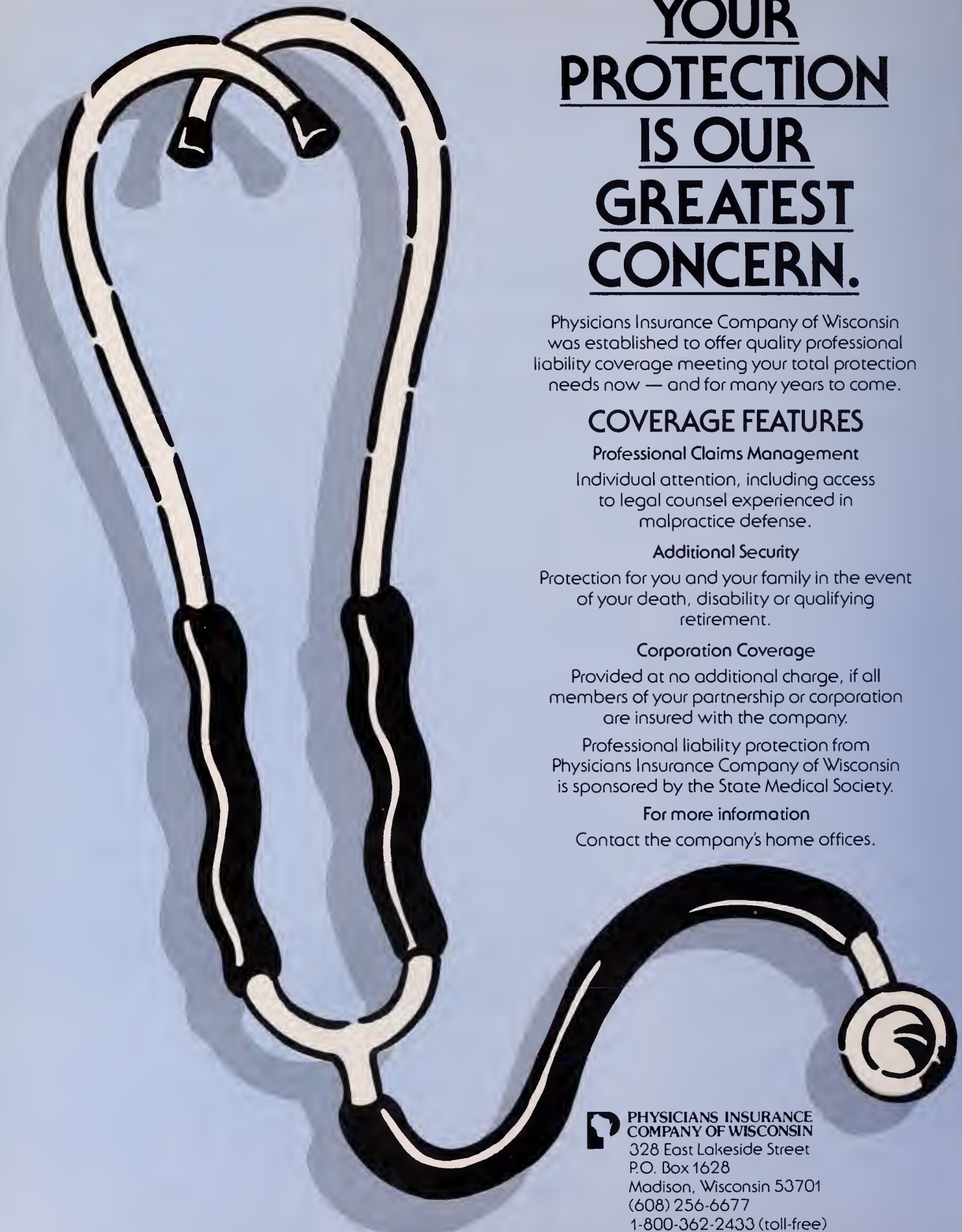
AMA, FDA to sponsor conference on investigational new drugs

The AMA and the Food and Drug Administration will cosponsor a conference entitled, "Treatment IND: Making Investigational New Drugs Available to the Desperately Ill," February 16-17 at the Grand Hyatt Hotel in Washington, DC.

The conference will focus on the implementation of the June 1987 FDA regulation allowing the use of INDs in the treatment of very ill patients for whom no effective treatment exists.

The program, designed for healthcare professionals and industry leaders, will address the practical considerations of making these drugs available, and the attending regulatory, legal, ethical, and economic issues. In addition, implications of this new regulation for the continued innovation, development, and availability of important advances in drug therapy will be analyzed.

Speakers will include representatives of the FDA, pharmaceutical industry, medical and research communities, medical insurers, and patient advocate groups. Among the scheduled speakers are: James H Sammons, MD, Executive Vice President, AMA; Frank E Young, MD, Commissioner, FDA; Theodore Cooper, MD, Chairman of the Board and Chief Executive Officer, The Upjohn Co; and Abbey S Meyers, Executive Director, National Organization for Rare Disorders.■



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New laws

• Admissibility of Panel findings reassured

Governor Thompson signed Senate Bill 246 into law Nov 25, 1987, hopefully removing any doubts about the admissibility of prior Patients Compensation Panel findings in circuit court actions.

The new law reiterates that the findings of formal panels must be admitted as evidence if either side introduces them. The law applies only to findings of formal panels under the old Patients Compensation Panel system which was eliminated nearly 18 months ago. It does not apply to mediation panels which do not use formal rules of evidence.

The restatement of panel findings' admissibility was sought by the State Medical Society after several plaintiff's attorneys sought rulings in circuit court to bar admissibility of this evidence. In legislation enacted in June 1986 eliminating the panel system, a provision was included to specify that prior panel findings would continue to be admissible in a subsequent court action. In spite of the Legislature's clear intent on this matter, however, a circuit court judge ruled last May in favor of a plaintiff attorney motion to bar the panel findings in the case from the jury. The physician won the case anyway, but the legal cloud needed to be cleared.

Senator Jerome Van Sistine and Assembly Majority Leader Tom Hauke, authors of the original language assuring admissibility, agreed that attempts to bar panel findings as evidence were a violation of their agreement and clearly against legislative intent. Because there were several cases pending on the admissibility question, and court rulings to date had been contradictory, SMS and these two legislators agreed that a restatement and elaboration of the law were warranted. Senate Bill 246 was then introduced by Senator Van Sistine and Representative Hauke, two key legislators on medical liability legislation who are often on opposite sides of the issue, and passed in October 1987.

The new law clarifies that the court must admit formal panel findings and orders, except the amount of damages awarded (assuming either side introduces the panel findings). It also reminds the courts that all discovery taken in a formal panel proceeding must be admitted, unless the discovery would otherwise be inadmissible under the rules of evidence (regardless of where and when discovery was done).

• Seat belts mandatory

Wisconsin's new seat belt law took effect on December 1, 1987 marking the start of a statewide publicity campaign by the Office of Highway Safety to encourage compliance.

The new law, signed by Governor Thompson on November 27, requires everyone to buckle up in vehicles mandated by federal law to be equipped with seat belts. Each designated seating position has had the seat belt equipment requirements since 1972. Under the new law, drivers are also responsible for passenger compliance for anyone under 16 years of age.

Although there are no demerit points assessed for violations of the seat belt law and only a $10 fine, court costs and other fees attached to the citation will increase a person's out-of-pocket costs to $32.90 if cited for a violation. Other provisions of the law include:

. . . secondary enforcement language that restricts the issuance of citations only when the traffic officer has stopped the vehicle for some other traffic offense.

. . . exemptions from mandatory seat belt use for rural newspaper and mail carriers, emergency personnel, taxi drivers and their passengers, and farmers operating vehicles off the road, such as tractors.

. . . an exemption for drivers who leave their vehicles 10 or more times per mile for job reasons, a concession added by legislators for garbage collectors and package delivery personnel.

. . . a medical exemption for those who carry a written statement from their physician noting that they cannot be properly restrained in a seat belt because of their physical or medical condition.

. . . language prohibiting juries from reducing damages by more than 15 percent for anyone injured in an accident who was not wearing a seat belt.

. . . a sunset date of June 30, 1989 or the first day of the month commencing after the Governor is informed by the federal government that the Wisconsin law satisfies federal criteria which could relieve automakers of complying with air bag requirements.

According to the Wisconsin Office of Highway Safety, a 15 percent increase in the use of seat belts can translate to 145 fewer traffic fatalities in our state. To test these projections as well as claims by the insurance industry that a seat belt law will reduce premiums, the new law also includes studies on highway safety impacts and the impact on the insurance industry, as well as a separate study on the use of seat belts in school buses.

Long a supporter of mandatory seat belt laws, the State Medical Society recognizes that the battle to ensure compliance is far from over. Efforts to extend the sunset date loom in the distance. The SMS also supports air bag requirements for automobiles, and it is our hope that Wisconsin's new seat belt law will not be regarded by the U.S. Department of Transportation as complying with federal criteria that could relieve car manufacturers of this future safety requirement.■

Ambulatory care survey completed

Wisconsin residents make 3.4 annual visits per person to office-based physicians, according to results of the 1986–1987 Wisconsin Ambulatory Medical Care Survey (WAMCS). This represents a 10 percent increase over the 1983–1984 survey rate of 3.1 visits per person. The annual visit rate varied according to age and sex, and increased by successive age groups, reaching 5.2 visits per year

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among persons age 75 years and older. The rate was also higher for females than males (3.6 for females, compared to 2.5 for males).

The WAMCS is a sample survey of physicians licensed in Wisconsin, conducted by the DHSS Division of Health, Center for Health Statistics. The University of Wisconsin Survey Research Laboratory collected data from nearly 500 physicians who were randomly selected to participate in the survey, which was conducted between April 1986 and March 1987. Each selected physician was asked to participate for one week and provide information on a sample of patient visits. The information provided on each patient visit included age, sex, and race of patient, payment source, diagnosis, reason for visit, disposition of visit, and services provided. Information also was obtained from each physician surveyed regarding type and size of practice.

The final report of the 1986–1987 WAMCS is now available. Requests for the report and questions or comments may be directed to Dale Wilson or Sue Schilling at: The Center for Health Statistics, PO Box 309, Madison, WI 53701; telephone 608-267-7266.■

Wisconsin Council of Professions slates 1988 officers

John K Scott, MD, Madison, a past president of SMS, will serve as secretary/treasurer for the Wisconsin Council of the Professions in 1988.

The Wisconsin Council of the Professions is comprised of the Wisconsin Chapter of the American Institute of Architects, the State Bar of Wisconsin, the Wisconsin Pharmaceutical Association, the Wisconsin Society of Professional Engineers, the Wisconsin Dental Association, the Wisconsin Veterinary Medical Association, the Wisconsin Society of Certified Public Accountants, and the State Medical Society of Wisconsin. Other officers for 1988 include Gary Berger, CPA, president, and John Rashke, Wisconsin Bar Association, as vice president. In addition, Virgil Simley, DDS will serve on the executive committee representing the dental association.

The Wisconsin Council of the Professions was created to promote a forum for dialogue among these professional associations in the state.■

PIC-Wisconsin names new director

Daniel P Schmidt of Middleton has been named a director of Physicians Insurance Company of Wisconsin (PIC-Wisconsin). He was appointed during a recent meeting of the company's board.

An administrator and medical group manager, Mr Schmidt is president and chief executive officer of Dean Medical Center in Madison. He holds both a bachelor of business administration degree and a master of arts degree in hospital and health administration from the University of Iowa.

Mr Schmidt is active in professional groups and organizations; is a member of the board of directors for Park Bank in Madison; and serves as an assistant clinical professor at the University of Wisconsin.

PIC-Wisconsin is a major provider of medical professional liability coverages, serving approximately 2900 individual physicians and medical groups in Wisconsin. The company offers coverage plans sponsored by the State Medical Society of Wisconsin.■

Crowd turns out for tort reform hearing

The Senate Judiciary and Consumer Affairs Committee, chaired by State Senator Lynn Adelman, held a public hearing at the State Capitol on Dec 3, 1987 on a series of bills aimed at reforming Wisconsin's tort system.

At the center of debate was Senate Bill 330, introduced by Senator David Helbach and Representative James Holperin at the request of business groups, physicians, and other health care providers, and more than 100 other organizations that make up the Coalition for Civil Justice.

The five major changes proposed in Senate Bill 330 are (1) a $250,000 cap on noneconomic damages, (2) eliminating joint and several liability, (3) prohibition of double recovery, (4) limiting punitive damages to cases of intentional acts, and (5) court review of attorney contingency fees.

More than 150 people testified on both sides of the tort reform issue throughout the afternoon. Opposing the bill were consumer and environmental groups, trial attorneys, and a newly formed organization called the Wisconsin Victims Network. Of surprise to some was the testimony of Arne Anderson, speaking on behalf of the 400-plus members of the Civil Trial Counsel of Wisconsin, an organization of defense attorneys. The defense attorneys opposed caps on noneconomic damages and limits on attorney contingency fees, and expressed reservations on other aspects of SB 330.

Testifying for SMS, Doctor Richard Roberts, discussed the impact of the medical liability crisis on the practice of medicine and accessibility of care. Doctor Roberts said, "The experience of other states, as well as independent research, clearly demonstrates that the types of reforms proposed in SB 330 can have a significant impact on medical malpractice premiums, and on the frequency and severity of malpractice claims."

"If we are to put the brakes on the engine that drives the liability crisis," he stated, "we need to reform our civil justice system. That system needs to promote fairness and equity, and must avoid ultimately destroying the very elements it intends to protect."

No action was taken by the Senate Committee following the hearing.■

Surcharge program for WHCLIP and Patients Compensation Fund started January 1

Starting January 1 physicians in WHCLIP and the Patients Compensation Fund (PCF) who exceed thresholds for number of claims paid or amounts paid may be surcharged through an increase in their PCF or WHCLIP premiums. A five-member peer review council has been created to review all claims paid and make recommendations to the board of governors as to the imposition of surcharges.

The surcharge is based on the number of claims and amounts paid to claimants by, or on behalf of, each provider during any five-year period. The surcharge, which increases with the number of claims paid and the total amounts paid, remains in effect for three years and may differ for different specialties. The percentage imposed decreases by 50% the second year and by 75% the third year if the provider does not accumulate any additional claims closed with payments.

Separate tables for physician classes have been established for WHCLIP and the PCF. For example, a Class 2 physician (Internal Medicine, Family Practice with minor surgery) under the PCF would be reviewed for a possible surcharge only if the physician had two or more claims which in aggregate totaled more than $123,000. A Class 4 physician (Neurology or Obstetrics/Gynecology) in the PCF would have to have three or more claims with an aggregate of over $503,000 before he or she would be reviewed for possible implementation of a surcharge.

The peer review council's duty is to review each provider who exceeds either threshold, by examining the provider's claims record, investigating mitigating circumstances, and determining whether each claim paid during the review period should be considered in determining the amount of surcharge. If the council recommends that a surcharge should be imposed, the provider is entitled to an administrative hearing prior to the board of governors issuing its final decision.

If members have any further questions about the surcharge, contact Kit Nimtz in the Division of Medical Policy and Practice at 1-800-362-9080 or 1-608-257-6781.■

SMS Medicare seminars to repeat in March

Because of the popularity of the November 1987 SMS seminars on Medicare, the State Medical Society will sponsor two additional seminars on March 23 in Lake Geneva and on March 25 in Stevens Point. These seminars will be identical to the seminars held in November. Watch upcoming *Medigrams* for the registration forms and more information.■

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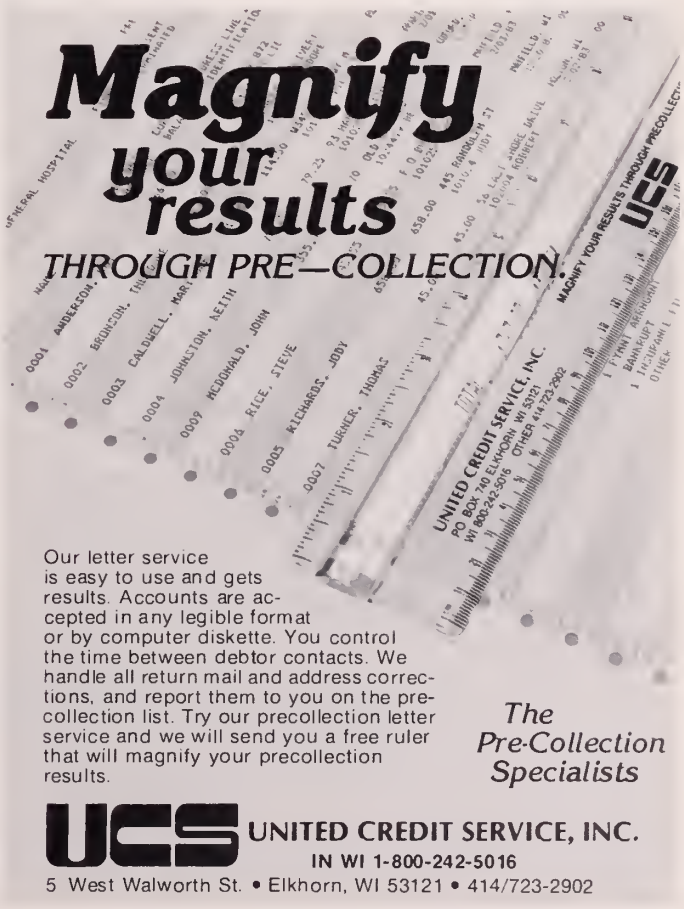

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PartnerCare push criss-crosses state

SMS and the Coalition of Wisconsin Aging Groups continue their joint effort to implement PartnerCare, the voluntary Medicare assignment program for low-income elderly. Eau Claire, Waushara, and Richland Counties are the latest counties to sign on with PartnerCare; they are being joined in January by Fond du Lac and Ozaukee Counties. Waukesha, Milwaukee, Dane, Winnebago, Outagamie, Price, Taylor, Waupaca, Walworth, Dunn, Barron, Oneida and Vilas Counties already take part in this cooperative effort to increase access to needed medical care for low-income seniors.

Additional counties preparing to introduce PartnerCare include Manitowoc, Marathon, Lincoln, Rock, Dodge, Langlade, Wood, and Green Lake. County Offices on Aging are gearing up, steering committees are forming, and volunteers are or will soon be trained to perform income verification.

"PartnerCare remains a top priority of the State Medical Society," asserted Kenneth M Viste, Jr, MD, President. "We appreciate the efforts of physicians in those counties already participating in PartnerCare, and we call upon all other physicians to join in our worthwhile effort." Statewide implementation of the program is expected by April 1988.■

Physicians Insurance Company top liability carrier

According to information compiled by SMS Services, Inc, the for-profit subsidiary of the State Medical Society of Wisconsin, Physicians Insurance Company of Wisconsin is, far and away, the largest medical liability insurer in the state.

With nearly 2,900 insured physicians and corporations representing over 41% of the total market, PIC-Wisconsin has become the dominant medical professional insurer in Wisconsin. Next largest is WHCLIP, the Wisconsin Health Care Liability Insurance Plan operated by the State of Wisconsin. With 1,900 insureds, WHCLIP has captured just over 27% of the market. Following WHCLIP are the following carriers: Medical Protective with 1,456 insureds or 20%; St Paul 524 or 7.6%; RLI, the American Psychiatric Association Plan, with approximately 1.8% of the market.

Three remaining insurers, Pacific Employers Mutual which offers pathologist coverage; National Union Fire Insurance providing coverage to emergency room physicians and American Home Assurance comprise less than 1% of the market.

Physicians Insurance Company of Wisconsin is a physician-owned and operated professional medical liability insurer which offers claims-made coverage to physician members of SMS.■

Gramm-Rudman-Hollings cuts Medicare reimbursement 2.324%

The Gramm-Rudman-Hollings deficit control law has reduced Medicare's reimbursement for services delivered on or after November 21, 1987. The Gramm-Rudman law will reduce Medicare payments by 2.324%. The following is an example of how the reductions will be implemented:

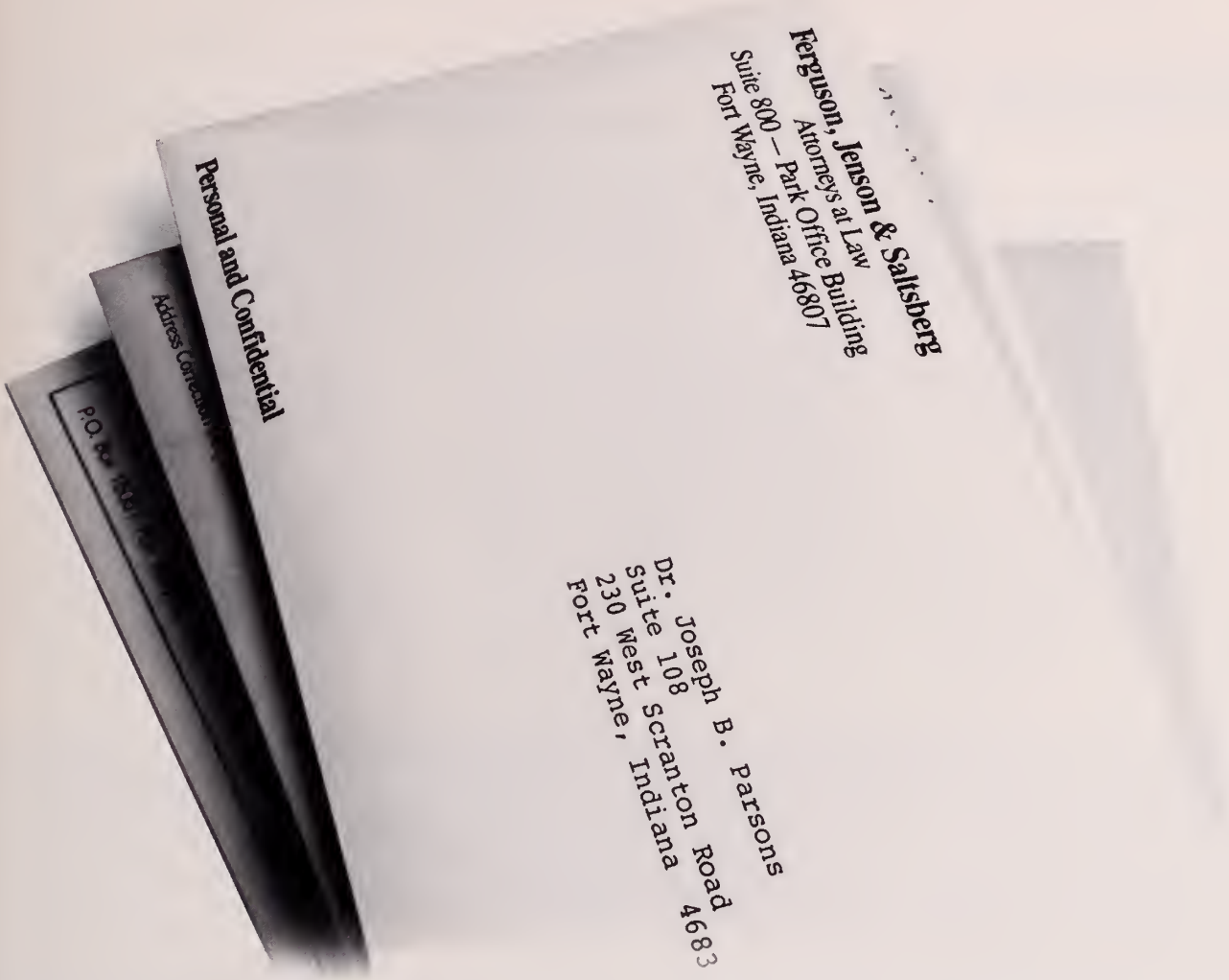
If Medicare normally approves $100 for a service and pays 80% of the approved charge, it would pay you $80. For services rendered on or after November 21st, your payment for $80 will be reduced by 2.324%, or $1.87, and you will be reimbursed $78.13. When assignment is not taken, the patient will be responsible to pay 20% of the Medicare approved amount, or $20 plus the $1.87 difference. The patient will not be responsible to pay the $1.87 difference when assignment is accepted. Any charges that fall under the patient's deductible are not influenced by this reduction.

These reductions will be in effect until Congress gives further notice.■

Skin problems in the elderly

A study in the December 1987 issue of *Archives of Dermatology* suggests skin problems are common among the elderly but that the dermatologic needs of this growing segment of the population are not being met. Solange Beauregard, MD, FRCP (C), of the Boston University Medical Center, and Barbara A Gilchrest, MD, of the US Department of Agriculture Human Nutrition Research Center on Aging at Tufts University, Boston, studied 68 noninstitutionalized volunteers aged 50 to 91 years (average age 74), using a questionnaire and total skin exam. Two-thirds of the group and 80 percent of those aged 80 years and older reported medical concerns regarding their skin, with itching the most common complaint. All study subjects had at least one cutaneous abnormality, say the authors, with symptomatic and/or medically significant disorders found in nearly 65 percent. However, "despite a high prevalence and long average duration of dermatologic concerns, very few subjects had consulted a physician for these problems," they add. A review of skin care regimens found "substantial limitations with regard to bathing, shampooing, and nail care." Despite some possible study limitations, the authors conclude, "It is clear that the elderly have many unmet dermatologic needs, some of substantial medical importance and all affecting their quality of life."—*AMA Brief Report*■

Crisis in black and white.



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PHYSICIAN BRIEFS

*Physician members of the State Medical Society of Wisconsin

David L Nelson, MD,* Stoughton, recently was named the 1987 local Edward D Jones, Sr Heart of Gold winner. This is the third annual Heart of Gold Award by the St Louis-based financial services firm. This award honors an individual who has dedicated his/her time and energy to helping those less fortunate than him or herself.

Marianne Clinton, MD, Eau Claire, has joined the medical staff of Sacred Heart Hospital in Eau Claire. A family practice physician, Doctor Clinton graduated from the University of California Irvine Medical School and completed her residency at Valley Medical Center in Fresno, CA. Prior to joining the medical staff of Sacred Heart Hospital, she was on the staff at the Jackson Municipal Hospital, Jackson, MN.

Bradley J Grewe, MD,* Eau Claire, recently became a member of the medical staff of the Midelfort Clinic. He graduated from the University of Wisconsin Medical School, Madison, and completed his general surgery residency at Southwestern Michigan Area Health Education Center in Kalamazoo, MI.

Kathleen M Wick, MD, Beloit, recently became associated with William A Pruett, MD* in the practice of family medicine. Doctor Wick graduated from the University of Wisconsin Medical School, Madison, and completed her residency in family practice at Wright State University School of Medicine in Yellow Springs, OH.

Craig D Barr, MD,* Sturgeon Bay, has joined the medical staff at the Door County Medical Center. He graduated from the University of Wisconsin Medical School, Madison, and served an internship at the La Crosse Lutheran Hospital/Gundersen Clinic. A residency in internal medicine was completed at the Marshfield Clinic.

Stephen J Roth, MD, Marshfield, has joined the medical staff of the Marshfield Clinic as a pediatric cardiologist. A native of New York City, Doctor Roth graduated from Albert Einstein College of Medicine in New York City, and served his residency in pediatrics at University of Wisconsin Hospital and Clinics, Madison. Prior to joining the Clinic, Doctor Roth had been on the staff of the University of Utah. He also completed a fellowship in pediatric cardiology at Texas Children's Hospital in Houston.

Paul P Carbone, MD,* Madison, director of the Wisconsin Clinical Cancer Center at the University of Wisconsin-Madison, recently received the American Cancer Society's Medal of Honor. The medal, the highest honor of the society, was awarded to Doctor Carbone in recognition of his 25 years of research in the care of cancer patients. Doctor Carbone has been at the University since 1976.

Kristin E Swanson, MD,* La Crosse, a family practitioner at Skemp-Grandview-La Crosse Clinic, recently was added to the medical staff of the Galesville Medical Clinic. Doctor Swanson graduated from the University of Iowa in 1984 and completed her family practice residency at St Francis Hospital, La Crosse, which is affiliated with the Mayo Medical School and the Mayo Graduate School of Medicine in Minnesota.

James J Wallace, MD,* Oconto, has joined the medical staff of Oconto Memorial Hospital. A family practitioner, Doctor Wallace graduated from the Michigan State University Medical School and served his residency at Muskego General Hospital in Michigan. Prior to coming to Oconto, Doctor Wallace practiced in Stephenson, MI.

Esther Kats, MD, La Crosse, a pediatric neurologist, has joined the medical staff of the Gundersen/Lutheran Medical Center of La Crosse. Doctor Kats graduated from the Voronezh Medical Institute in the Soviet Union and had practiced there until 1982. Her internship and residency in pediatrics was completed at Gundersen Medical Foundation-Lutheran Hospital, and a pediatric neurology residency was completed at the University of Minnesota Hospitals in Minneapolis. Doctor Kats also completed a fellowship in epilepsy at the Bowman-Gray School of Medicine of Wake Forest University, Winston-Salem, NC.

David King Aymond, MD,* Sheboygan ophthalmologist, recently accepted a position as medical advisor for the National Society to Prevent Blindness. Doctor Aymond graduated from the University of Texas Medical School and completed his residency at the University of Texas in Galveston.

Joseph B Durst, MD,* La Crosse obstetrician-gynecologist at the Skemp-Grandview-La Crosse Clinic, retired Oct 1, 1987. Doctor Durst, a 1951 graduate of Marquette University School of Medicine, completed his internship and residency in obstetrics-gynecology at Milwaukee County Hospital and began his medical practice in La Crosse in 1955. He is a former president of the medical staff at St Francis Medical Center, past president of the La Crosse County Medical Society, and past president of the Wisconsin Society of Obstetrics and Gynecology.

Steven C Adamson, MD,* has become a member of the medical staff of the Midelfort Clinic in the Department of Family Practice. A graduate of Mayo Medical School, Rochester, MN, Doctor Adamson also completed his family practice residency at the Mayo Graduate School of Medicine in Rochester.

Donald R Griffith, MD,* Eau Claire, medical director of the Midelfort Clinic, recently received the 1987 American College of Medical Group Administrators Medical Executive Award. The award, which was presented in Washington, DC, recognizes achievement and leadership in medical management. The Midelfort Clinic was established in 1927.

R William Roberts, MD,* Oshkosh, recently became associated with the medical staff in the department of urology at St Agnes Hospital in Fond du Lac. Doctor Roberts graduated from the University of Iowa Medical School and completed his urology residency at the Veterans Administration Hospital in Des Moines, IA. He continues to practice in Oshkosh, but also has new offices in Fond du Lac with the clinic of Robert H Mikkelsen, MD.*

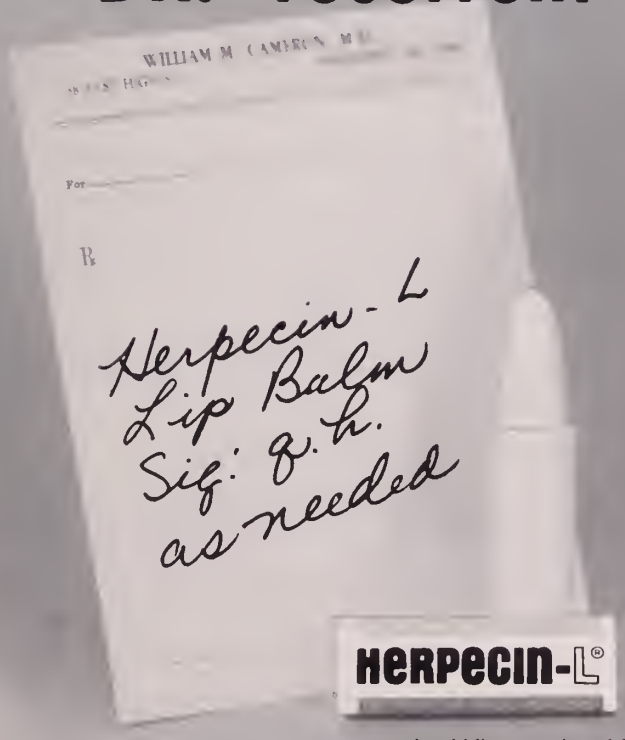
Lloyd E Hendrix, MD,* Menomonee Falls, has been appointed instructor of radiology at the Medical College of Wisconsin, Milwaukee. He is associated at Froedtert Memorial Lutheran Hospital in Wauwatosa. He recently completed a neuroradiology fellowship at the Medical College of Wisconsin Affiliated Hospitals. Doctor Hendrix graduated from the University of Kansas School of Medicine.

James E Cauley, MD,* Oshkosh, recently joined the medical staff in the department of urology at St Agnes Hospital in Fond du Lac. Doctor Cauley graduated from the Indiana University School of Medicine and completed his urology residency at the Medical College of Wisconsin in Milwaukee. He continues to practice in Oshkosh, but also has new offices in Fond du Lac with the clinic of Robert H Mikkelsen, MD.*

Kristine M Klewin, MD, Brookfield, has joined Ingrid E Jurevics, MD* at Brookfield Eye Physicians, SC. Doctor Klewin also is an assistant clinical professor at the Medical College of Wisconsin in the Department of Ophthalmology with a subspecialty in glaucoma.

Karl M Hoffmann, MD,* Mayville, has opened his medical practice in Mayville. Doctor Hoffmann graduated from the University of Wisconsin Medical School, Madison, and completed an internship at St Joseph's Hospital in Milwaukee. His residency in family practice was completed at West Virginia University Hospital, followed by a fellowship in obstetrics at Marshall University in West Virginia.■

Dx: recurrent herpes labialis



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"HERPECIN-L appears to actually **prevent** the blisters . . . used **soon enough.**" DDS, MN

"HERPECIN-L®. . . a **conservative approach** with **low risk/high benefits.**" MD, FL

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"(In clinical trials) **. . . response** was **dramatic. HERPECIN-L . .** proven **far superior.**" DDS, PA

"All patients claimed **shorter duration . . .** at **prodromal symptoms . . .** HERPECIN-L **averted** the attacks." MD, AK

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YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

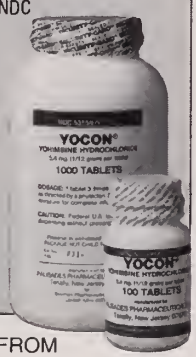
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85

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CARAFATE®
(sucralfate)

BRIEF SUMMARY

CONTRAINDICATIONS
There are no known contraindications to the use of sucralfate.

PRECAUTIONS
Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that the simultaneous administration of CARAFATE with tetracycline, phenytoin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. The clinical significance of these animal studies is yet to be defined.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No evidence of drug-related tumorigenicity was found in chronic oral toxicity studies of 24 months' duration conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies have not been conducted.

Pregnancy: Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients, adverse effects were reported in 121 (4.7%). Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

DOSAGE AND ADMINISTRATION
The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED
CARAFATE (sucralfate) 1-gm pink tablets are supplied in bottles of 100 and in Unit Dose Identification Paks of 100. The tablets are embossed with MARION/1712. Issued 3/84

References:

1. Korman MG, Shaw RG, Hansky J, et al: *Gastroenterology* 80:1451-1453, 1981.
2. Korman MG, Hansky J, Merrett AC, et al: *Dig Dis Sci* 27:712-715, 1982.
3. Brandstaetter G, Kratochvil P: *Am J Med* 79(suppl 2C):36-38, 1985.
4. Marks IN, Wright JP, Gilinsky NH, et al: *J Clin Gastroenterol* 8:419-423, 1986.
5. Lam SK, Hui WM, Lau WY, et al: *Gastroenterology* 92:1193-1201, 1987.

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Ulcer therapy that won't yield, even to smoking

What do you do for duodenal ulcer patients who should stop smoking, but won't? Both cimetidine[1] and ranitidine[2] have been shown less effective in smokers than nonsmokers.

Choose CARAFATE® (sucralfate/Marion). Two recent studies show Carafate to be as effective in smokers as nonsmokers.[3,4] A difference further illustrated in a 283-patient study comparing sucralfate to cimetidine[5]:

Ulcer healing rates:
(at four weeks of therapy)[5]

Sucralfate:	
All patients	79.4%
Smokers	81.6%*
Cimetidine:	
All patients	76.3%
Smokers	62.5%

*Significantly greater than cimetidine smoker group ($P<.05$).

Carafate has a unique, nonsystemic mode of action that enhances the body's own ulcer healing ability and protects the damaged mucosa from further injury.

When your ulcer patient is a smoker, prescribe the ulcer medication that won't go up in smoke: safe, nonsystemic Carafate.

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sucralfate/Marion

Please see adjoining page for references and brief summary of prescribing information.

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Motrin® 800 mg TABLETS
ibuprofen

Extra strength
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J-6138 January 1986

*Physician members of the State Medical Society of Wisconsin

Mercy Medical Center, Oshkosh, during the annual medical staff business meeting, elected Paul C O'Connor, MD* as its president of the medical staff. Other officers are Edwin L Downing, MD,* vice president, and Roy E Buck,* secretary, both of Oshkosh.

Wausau Medical Center, at its annual meeting, elected Steven C Stoddard, MD,* president for one year. Doctor Stoddard has been a member of the medical staff since 1978. Other officers elected are MDs Dale B Anderson,* vice president, and Thomas A Starkey,* secretary-treasurer. Doctor Anderson has been associated with the Center since 1974 and Doctor Starkey since 1970. MDs John E Bobinski* and Arthur M Waldman* were elected to three-year terms on the center's board of directors, and Phillip R Albert* and Daniel M Seybold* were elected to two-year terms on the board of directors.

Harold M Coon Memorial Award for Excellence in Hospital Administration, recently was awarded to Stewart Laird, president and chief executive of the Franciscan Health System. The Franciscan Medical System includes St Francis Medical Center, La Crosse; St Joseph Hospital, Arcadia; the Caledonia Health Care Center, Caledonia, MN, and St Mary's Hospital in Sparta. Also included are five skilled nursing homes, 11 elderly living centers, five physician clinics, 10 physician office buildings, and 23 mental health and chemical dependency centers in Wisconsin, Minnesota, and Iowa.■

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Air Force medicine is one of our best benefits. The Air Force needs physicians such as you to keep it that way. Most administrative responsibilities are in the hands of others, giving you the time to give full attention to the patients' needs. Our hospitals are staffed with dedicated, competent professionals to assist you. You'll have time for your family and to keep abreast of the latest methods and technologies that you don't have time for now. We also offer unlimited professional development and financial security. Find out more about Air Force medicine. Contact your nearest Air Force recruiter. Call

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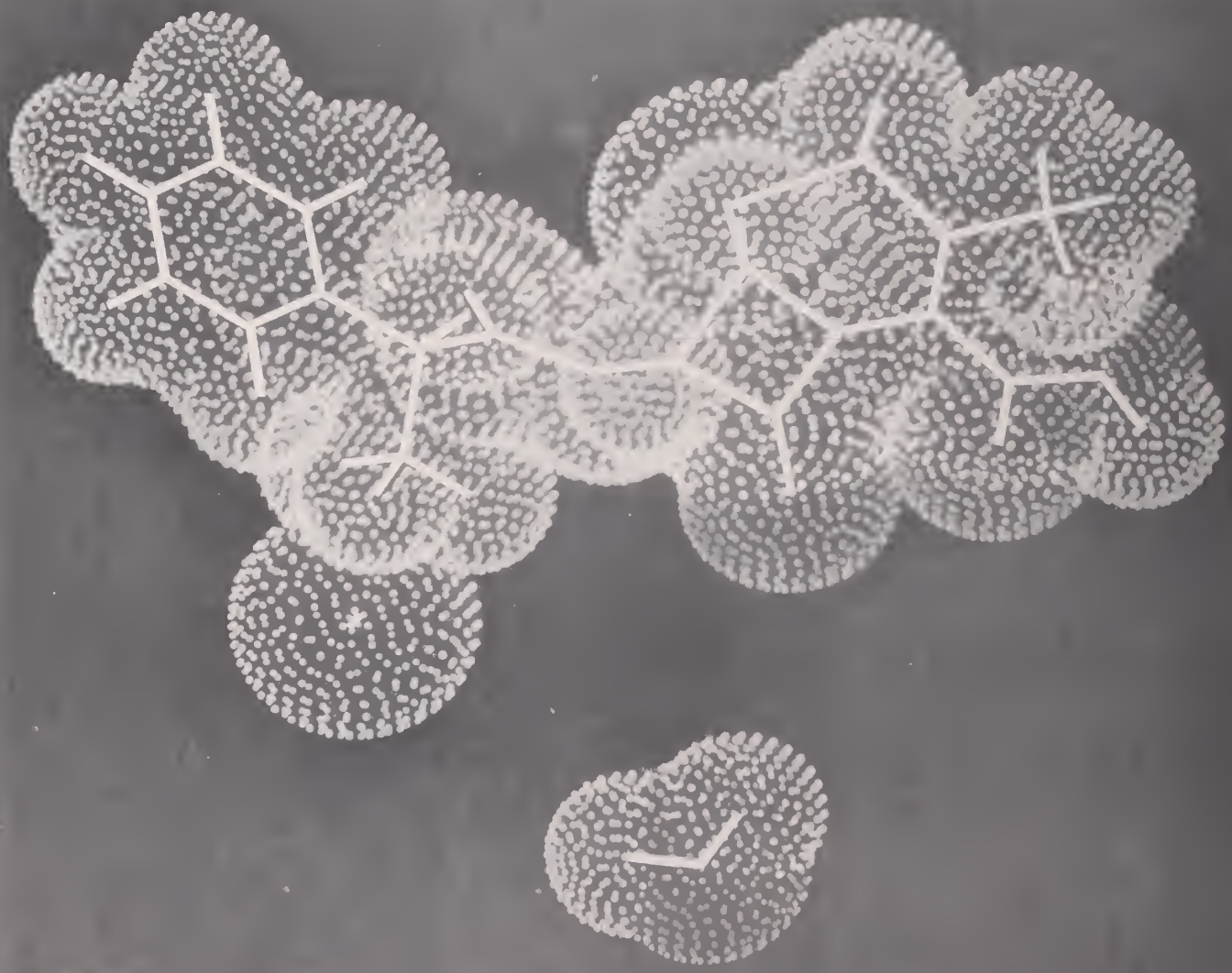
cephalexin hydrochloride monohydrate



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Computer-generated molecular structure of cephalexin hydrochloride monohydrate

Convenient 500-mg b.i.d. dosage and demonstrated effectiveness for treatment of:

- ☐ skin and skin structure infections*
- ☐ uncomplicated cystitis†
- ☐ pharyngitis‡

- New hydrochloride salt form of cephalexin—requires no conversion in the stomach before absorption
- Well-tolerated therapy

- May be taken without regard to meals

For other indicated infections, 250-mg tablets available for q.i.d. dosage

Priced less than Keflex® (cephalexin)

Keftab is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-sensitive patients.

Penicillin is the drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever.

*Due to susceptible strains of *Staphylococcus aureus* and/or β-hemolytic streptococci
†Due to susceptible strains of *Escherichia coli*, *Proteus mirabilis*, and *Klebsiella* sp
‡Due to susceptible strains of group A β-hemolytic streptococci.

KEFTAB™
(cephalexin hydrochloride monohydrate)

Summary: Consult the package literature for prescribing information.

Indications and Usage:

Respiratory tract infections caused by susceptible strains of *Streptococcus pneumoniae* and group A β-hemolytic streptococci.

Skin and skin structure infections caused by susceptible strains of *Staphylococcus aureus* and/or β-hemolytic streptococci.

Bone infections caused by susceptible strains of *S aureus* and/or *Proteus mirabilis*.

Genitourinary tract infections, including acute prostatitis, caused by susceptible strains of *Escherichia coli*, *P mirabilis*, and *Klebsiella* sp.

Contraindication: Known allergy to cephalosporins.

Warnings: KEFTAB SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Keftab in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Keftab should be administered cautiously in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy and lactation. Cephalexin is excreted in mother's milk. Exercise caution in prescribing Keftab for these patients.
- Safety and effectiveness in children have not been established.

Adverse Reactions:

- *Gastrointestinal*, including diarrhea and, rarely, nausea and vomiting. Transient hepatitis and cholestatic jaundice have been reported rarely.
- *Hypersensitivity* in the form of rash, urticaria, angioedema, and, rarely, erythema multiforme, Stevens-Johnson syndrome, or toxic epidermal necrolysis.
- *Anaphylaxis* has been reported.
- *Other reactions* have included genital/anal pruritus, genital moniliasis, vaginitis/vaginal discharge, dizziness, fatigue, headache, eosinophilia, neutropenia, and thrombocytopenia; reversible interstitial nephritis has been reported rarely.
- Cephalosporins have been implicated in triggering seizures, particularly in patients with renal impairment.
- *Abnormalities in laboratory test results* included slight elevations in aspartate aminotransferase (AST, SGOT) and alanine aminotransferase (ALT, SGPT). False-positive reactions for glucose in the urine may occur with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

PV 2060 DPP [091887] 849336

OBITUARIES

Lee G Eby, MD, 67, Whitefish Bay, died Oct 21, 1987 in Whitefish Bay. Born Jan 10, 1920 in Sheboygan, Doctor Eby graduated from the University of Wisconsin Medical School, Madison, and served his internship at Cincinnati General Hospital in Ohio. His residency in ENT was completed at the Mayo Clinic in Rochester, MN. Doctor Eby, an emeritus clinical professor of surgery at the Medical College of Wisconsin, was in private practice in Milwaukee from 1951 until 1987. He was on the medical staff at St Joseph's Hospital, Good Samaritan Medical Center, Children's Hospital of Wisconsin and Columbia Hospital. He was also on the consulting staff at the Veterans Administration Medical Center in Wood. He was a member of the Milwaukee County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Lorna, Whitefish Bay; two sons, Dr Thomas L (Mary) Birmingham, AL, James R (Kerry) of Milwaukee, and one daughter, Patricia of St Louis Park, MN.

Thomas E Dugan, MD, 58, Naples, FL, formerly of Waukesha, died Oct 25, 1987. Born May 27, 1929 in Milwaukee, Doctor Dugan graduated from Marquette University School of Medicine and served his internship at Milwaukee County General Hospital. His residency was completed at Evangelical Deaconess Hospital in Milwaukee. Doctor Dugan was on the medical staff of Waukesha Memorial Hospital and had served as chief-of-staff from 1969–1974. He also had served as chairman of the Division of Family Practice; chairman, Bylaws Committee; chairman, Emergency Room Committee, and chairman, Nominating Committee. He was president of the Southeast Chapter of the Wisconsin Academy of Family Physicians and had served as president of the Waukesha County Medical Society in 1965–1966. He also was a member of the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Patricia; six daughters, Josephine Cabezas, Potomac, MD; Mary Beth Croze, Milwaukee; Hannah Dugan, Milwaukee; Honore Dugan, St Paul, MN; Amy Dugan, Waukesha; and Cordelia Dugan of St Paul, MN; two sons, Thomas C, Boston, MA, and Hugh Dugan, Washington, DC; and stepchildren, Jeffrey Kablitz, Waukesha, and Jennifer Helmke of Las Vegas, NV.■

CES Foundation
of the State Medical Society of Wisconsin

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin recognizes the generosity of the following individuals and organizations who have made contributions during the month of October 1987.

Lakeside Endowment Fund—Asset Liquidation
University of Wisconsin

Earl R Thayer Lecture Fund
Ann Bardeen-Henschel, MD
Thomas J Doyle, MD
Vincent W Nordholm, MD
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Memorials
Kristin L Bjurstrom
Donald G Dieter, MD
Douglas County Medical Society
Dr and Mrs Richard W Edwards
Dr and Mrs Eugene J Nordby
State Medical Society of Wisconsin

Memorialized
Mrs Hazel Conway
Emmett H Kemna
William W Pfeifer, MD
Robert Reibold, MD
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Jefferson County Medical Society and Auxiliary
Milwaukee County Medical Society Auxiliary

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PHYSICIANS EXCHANGE

Rheumatologist—the Racine Medical Clinic a 34-physician multispecialty group conveniently located between Chicago and Milwaukee. Well equipped clinic offering salary guarantee with incentive bonus; excellent fringe benefits and early ownership. Please send curriculum vitae to: R D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 11tfn/87

BC/BE General Internist to join 26-MD multispecialty group with four internists, one nephrologist and one gastroenterologist. Top salary first year, full incentive thereafter. Central Wisconsin university town with drawing area of 80,000. Send CV to Dr John Gauder, Rice Clinic, SC, 2501 Main St, Stevens Point, WI 54481, or call collect 715/344-4120. 12tfn/87

General Surgeon. Board-certified general surgeon needed to join expanding 85-physician multispecialty medical center in Los Angeles and Orange counties. An exceptional base salary and incentive plan. Benefits include malpractice insurance, group health and life insurance. Please send CV to Dept 604 in care of the Journal. 12/87;1-2/88

Neurologist. Experienced neurologist needed to join expanding 85-physician multispecialty medical center in Los Angeles and Orange counties, with existing neurological practice. An exceptional base salary and incentive plan. Benefits include malpractice insurance, group health and life insurance. Please send CV to Dept 605 in care of the Journal. 12/87;1-2/88

Internal Medicine. Six physician general internal medicine practice in Duluth seeks BC/BE internist to replace retiring senior partner in their busy group. Competitive guaranteed salary and fringe benefits. Call or write L Timothy Knutson, Medical Resource Group, Inc, 2550 University Avenue, W, Suite 239, St Paul, MN 55114; ph 612/647-0003. p12/87; 1-2/88

RATES: 50¢ per word, with a minimum charge of $20.00 per ad BOXED AD RATES: $25.00 per column inch. *All ads must be prepaid.*

DEADLINE: Copy must be received by the 15th of the month preceding month of issue; *eg*, copy for the August issue is due July 15. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 1-800-362-9080.

Wanted—Medical Director. 35 hours per week; liability insurance paid; $35,000 per year. Please send resume with active licenses and telephone number to Fred Hrachovina, DO, Suite 23, 740 North Miami Beach Blvd, North Miami Beach, FL 33162. 1/88

Family Practice. Marshfield Clinic Department of Family Medicine has an opportunity for a BE/BC family practice specialist to join its six-member group. This position offers a high quality fulfilling practice with both inpatient and outpatient responsibilities. This physician would enjoy the support of one of the nation's largest multispecialty groups. Unique rural setting, excellent salary, plus extensive fringe benefits. Reply with CV to Steven M Fontanini, DO, Chairman, Department of Family Practice, Marshfield Clinic, 1000 North Oak Ave, Marshfield, WI 54449 or call collect 715/387-5168. 1/88

Locum tenens physician. Join a comprehensive physician support service with a major medical center in south central Montana. Locum physicians provide primary care coverage (excluding routine OB) for physicians in rural Montana and Wyoming. Assignments vary in length. Reimbursement for expenses, malpractice, health insurance, CME. Call Locum Tenens Coordinator, 1-800/325-1774 or send CV to 1500 Poly Drive, Suite 103, Billings, MT 59102. p12/87; 1/88

Wisconsin. Physician interested in practicing emergency medicine to join an established ER group located in east central Wisconsin. Candidate must be certified or certifiable. ACLS/ATLS training desirable. ER operation includes ground ambulances and helicopter. Full range of specialty support. Structured hours with flexible work schedule. Excellent compensation. Contact Dept 606 in care of the Journal. p12/87; 1/88

Wisconsin. OB/GYN (BC/BE) needed to join dynamic HMO-based multispecialty group practice. University town of 55,000 near Minneapolis. Community and recreation outstanding. Competitive salary and fringes. We take pride in our patient care. Contact: Robert A Braastad, MD, Group Health Cooperative, 1030 Regis Court, Eau Claire, WI 54701; ph 715/836-8552. p12/87;1-4/88

Family doctor needed! Small town living, large city conveniences. Proven community need for local doctor. Modern facility in Omro, eight miles west of Oshkosh. 330-bed hospital 20 minutes away. Available for lease or purchase. Contact Schwab Realty Ltd, 435 Algoma Blvd, Oshkosh, WI 54901; ph 414/233-4184. 1/88

Dermatologist, Pediatrician, Oncologist, Pathologist, Otorhinolaryngologist, Psychiatrist, Endocrinologist, Orthopedist, General/Family Practitioner. Excellent opportunity for physicians in Los Angeles suburb to join 90-member multispecialty medical group. Large fee-for-service and prepaid practice, no Medi-Cal. Excellent compensation program based on guarantee plus incentive, profit-sharing and pension plan. Group provides health, dental, life, and malpractice. Partnership in real estate and medical corporation available. Send CV to Ron McDaniel, Assistant Administrator, Mullikin Medical Center, 17821 S Pioneer Blvd, Artesia, CA 90701. 12/87;1-2/88

St Francis Medical Center—La Crosse. Full-time faculty position with opportunity for teaching and practice in the St Francis/Mayo Family Practice Residency with Mayo Clinic faculty appointment. Currently, 3½ full-time family physicians and 13 residents in clinic and hospital. Send inquiries to Ted Thompson, MD, Program Director, St Francis/Mayo Family Practice Residency, 700 West Avenue South, La Crosse, WI 54601; ph 608/785-0940. 12/87;1/88

Physician. Excellent opportunity for a family practitioner to join multifaceted clinic in northern Wisconsin located in a recreational environment. Good benefits and competitive salary. Submit resume or call 715/799-3495. Menominee Indian Tribe, PO Box 397, Keshena, WI 54135. 12/87;1-2/88

Green Bay, Wisconsin. Twenty-eight physician multispecialty group seeking BC/BE physicians in the following specialties: Family Practice, Pulmonology, Pediatrics, ENT, and Anesthesiology. Green Bay is a progressive community with an easy lifestyle, ample outdoor activities, excellent schools and cultural activities. The Clinic offers competitive salary and excellent fringe benefits. Please send CV to: P M Kindrachuk, Administrator, West Side Clinic, sc, Post Office Box 19070, Green Bay, WI 54307-9070. 12/87;1-3/88

Orthopedic Surgeon. Board-certified/Board-eligible to join a 23-physician multispecialty group in Winona, Minnesota. Total patient population draw area of 40,000. Interested physicians please contact: J B Knuesel, Administrator, Winona Clinic, Ltd, 420 East Sarnia, Winona, MN 55987. 11-12/87;1-88

For Emergency Physician who possesses excellent clinical and trauma skills within a group of 7 Emergency Room physicians located in beautiful northwest Wisconsin area. Please send CV to: Dr M Jaghlit, 900 W Clairemont Ave, Eau Claire, WI 54701 or call 715/839-4404. 9-12/87;1-2/88

PHYSICIANS EXCHANGE

continued

Indiana. Prosperous residential community in northern Indiana is seeking a dermatologist. Twenty-three physician group looking to add a second dermatologist to a rapidly growing practice. Excellent academic affiliation with the University of Notre Dame located nearby. Contact: Jean Ecos, 250 Regency Ct, Waukesha, WI 53186; ph 414/785-6500 (collect). 12/87;1/88

Pediatrician to join existing two-person practice at the 23-physician multispecialty Winona Clinic, Ltd, in Winona, Minnesota. Located in the beautiful Mississippi River Valley of southeast Minnesota. The community with a 40,000 population trade area is the host of three colleges and a diverse industrial base. Send CV to J B Knuesel, Administrator, Winona Clinic, Ltd, 420 East Sarnia, Winona, MN 55987. 11-12/87;1/88

Twenty-nine physician multispecialty clinic located in desirable East Central Wisconsin location is seeking Board-certified or Board-qualified orthopedic surgeon to round out its services. Lab, x-ray, excellent hospital. Liberal guarantee and benefits. If interested contact D F Sweet, MD, Fond du Lac Clinic, SC, 80 Sheboygan St, Fond du Lac, WI 54935. 9tfn/87

Internal Medicine. Board-certified or eligible to join four general internists in a multispecialty group in northeastern Wisconsin. Office is next to two hospitals. Partnership is available after one year. Send CV to Dept 596 in care of the Journal. p8-12/87; 1/88; 2-4/88

General Internist. Board-certified or Board-eligible for acute medical care position. Also provides coverage in expanding Medical Outpatient Unit. Competitive base salary plus VA Physicians Special Pay. Thirty days paid vacation; Federal malpractice protection; institution approved Category I CMEs; relocation expenses; other Federal service fringe benefits. Tomah is a progressive city of 7500 located in west central Wisconsin. Predominantly rural setting offers four season outdoor recreation, clean air, good schools, and affordable housing. Call or send CV: K S Prathipati, MD, Chief Medical Service (118), VA Medical Center, Tomah, WI 54660; 608/372-3971, ext 307. EO/AAE. 1-2/88

Baraboo, Wisconsin. Emergency Department at St Clare Hospital seeks full and part-time physicians. Eight thousand annual visits. Hourly compensation. Pleasant area in which to live, near Devil's Lake, and the Baraboo Hills. Also, Madison nearby. Contact: Mr Ronald Levy, Executive Director, St Clare Hospital, 707 14th St, Baraboo, WI 53913; ph 608/356-5561. p1/88;2/88

BC/BE Internist. Outstanding opportunity for general internist to join two active internists in a growing practice of internal medicine in a friendly rural community in northeastern Wisconsin near Green Bay. New clinic attached to a 55-bed community hospital with new ICU/CCU. Excellent long-term growth potential. Send CV to Artwich Clinic, Ltd, 835 South Main St, Oconto Falls, WI 54154. p9-12/87; 1/88

Wanted—Board qualified—board certified obstetrician-gynecologist as an associate. Modern well equipped facility. Excellent starting salary and benefits including profit sharing plan. Please contact Elizabeth Allen Steffen, MD, 734 Lake Ave, Racine, Wis 54303. 9tfn/83

West Bend, Wisconsin, General Clinic, a 20-physician multispecialty group is seeking additional B/C, B/E physicians in **Family Practice, Pediatrics, OB/GYN, Internal Medicine, Urology, Dermatology,** and **ENT.** First-year salary and benefits guaranteed. Corporate association after one year. Located in a family-oriented, economically strong small city surrounded by four-season recreational and scenic Kettle Moraine area 30 miles north of metropolitan Milwaukee. Contact Hans W Schmelzling, Administrator, 279 S 17th Ave, West Bend, WI 53095; ph 414/338-1123. 7tfn/87

Beloit Clinic, SC, an expanding multispecialty group in a southern Wisconsin college town is seeking an internist, pediatrician, and family practitioner for second satellite clinic; and an additional BC/BE cardiologist and BC/BE neurologist for main facility. Guaranteed salary with incentive plus excellent fringe benefits. Send CV to James F Ruethling, Administrator, Beloit Clinic, SC, 1905 Huebbe Parkway, Beloit, WI 53511; ph 608/364-2200. 6tfn/87

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7-12/87; 1-6/88

Primary Care. Primary care physician to work in "Walk-In" Department of 24-physician multispecialty clinic. 12 to 15 hours per week. Excellent back-up services. Complete lab and x-ray on-site. Lodging accommodations available. Contact: Administrator, Rice Clinic, 2501 Main St, Stevens Point, WI 54481 or call collect 715/344-4120. 6tfn/87

Excellent opportunity for a Board certified or eligible **ob/gyn** to practice in conjunction with a 4-member OB/GYN Department of a 28-member multispecialty group. The group is located in southeastern Wisconsin, in a city of 100,000 between two major metropolitan areas. If interested, please send CV to: William H Olson, Kurten Medical Group, 2405 Northwestern Ave, Racine, WI 53404. All inquiries will be kept confidential. 5tfn/86; c1tfn/88

Physicians needed full- or part-time to perform light physicals. Milwaukee area. Professional liability provided. Phone 414/344-2100, Ms Jenkins. 10tfn/84

Primary Care Physicians—Family Practice, General Practice, or ER experience desirable. To staff clinics for industrial, walk-in, after hours, and satellite medicine. Excellent opportunity—guaranteed salary, profit-sharing, great fringes. Send CV to Administrator, Manitowoc Clinic, PO Box 3008, Manitowoc, WI 54220. p7-12/87; 1-5/88

Family Practice—Madison, Wisconsin. Eleven-year-old staff model HMO has a family practice position available. We offer a very attractive practice setting with reasonable scheduling, excellent salary and benefits. Contact: John Hansen, MD, Medical Director, Group Health Cooperative, One South Park, Madison, WI 53715; ph 608/257-9700. 1-3/88

Medical oncologist. Central Wisconsin of 50K needs aggressive Board eligible/certified physician with entreprenurial skills to develop market of 200K with one other medical oncologist. Compensation/benefits package with minimum salary of $130K plus 100% of collections after expenses and office space. Contact Bob Sweat. Tyler & Company, 9040 Roswell Rd, Atlanta, GA 30350. Call 404/641-6411. p1/88

Eagle River—Great opportunity for two BC/BE family practice physicians to join well-established practice. Guaranteed annual income and future partnership available. For more information, send resume to Judy Harris, Recruiter, UW Office of Rural Health, 810 University Bay Dr, Madison, WI 53705 or call collect 608/263-7933. 1tfn/88

MEDICAL FACILITIES

Outstanding office-based psychiatric practice available in southwestern Wisconsin. Principal office located in Madison, Wisconsin, with clients in several outlying communities. Current net $100,000. Available in April or May 1988. Partial financing offered. Contact Dept 609 in care of the Journal.
p1/88

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MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

WISCONSIN

FEBRUARY 9-11, 1988: *Indianhead Symposium & Ski Outing,* at Lakewoods, Cable. Eight hours CME. Contact: WAFP, 850 Elm Grove Rd, Elm Grove, WI 53122; ph 414/784-3656. 9-12/87;1/88

MARCH 19, 1988: Wisconsin Dermatological Society, University Hospital and Clinics, Madison. 12tfn/87

APRIL 9, 1988: *9th Annual Trauma Seminar, Occupational Injuries,* Gundersen Clinic/La Crosse Lutheran Hospital, La Crosse. Info: Darlene Kleba, Trauma and Emergency Center, La Crosse Lutheran Hospital, 1910 South Ave, La Crosse, WI 54601; ph 608/785-0530, ext. 3508. 1-2/88

APRIL 22, 1988: *Wisconsin Chapter-American Academy of Pediatrics* Annual Meeting, at the American Club, Kohler. Theme: "Renal diseases: A Wisconsin perspective on hypertension, hemolytic uremic syndrome, and primary care concerns." Contact Carl Eisenberg, MD: 414/352-3100.
g11-12/87; 1-3/88

APRIL 26, 1988: *Wisconsin Academy of Ophthalmology,* held in conjunction with the Milwaukee Opthalmic Society meeting, University Club, Milwaukee. Info: 414/259-1930 (Arleen). g1-3/88

APRIL 28-30, 1988: State Medical Society of Wisconsin Annual Meeting, Milwaukee.

JUNE 3-4, 1988: Wisconsin Radiological Society and the Milwaukee Roentgen Ray Society, American Club, Kohler.
g11-12/87;1-5/88

JUNE 16-19, 1988: Wisconsin Academy of Family Physicians, Holiday Inn, Stevens Point. g10tfn/87

JULY 12-21, 1988: *Wisconsin Society of Obstetrics and Gynecology,* Landmark Resort, Egg Harbor. g1-6/88

JULY 29-31, 1988: Wisconsin Dermatological American Club, Kohler. 12tfn/87

SEPT 9-11, 1988: Wisconsin Society of Anesthesiologists, Convention Center/Embassy Suites, Green Bay. g10tfn/87

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 50¢ per word, with a minimum charge of $20.00 per listing. *All listings must be prepaid.*

BOXED LISTINGS: $25.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors

COPY DEADLINE for listings is 15th of the month preceding the month of publication; *eg,* copy for the August issue is due by July 15. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 1-800-362-9080.

FOR LISTING of other meetings see the July 3, 1987 issue of the *Journal of the American Medical Association:* Continuing Education Opportunities for Physicians for period September 1987 through February 1988.

SEPT 15-17, 1988: Wisconsin Society of Internal Medicine, Milwaukee Marriott.
g10tfn/87

SEPTEMBER 30-OCTOBER 1, 1988: Wisconsin Radiological Society, Concourse Hotel, Madison. g11-12/87;1-8/88

OTHERS

FEBRUARY 18-19, 1988: *Winter Pediatric Seminar.* Powderhorn Lodge in Bessemer, Michigan. Info: Marshfield Clinic's Office of Medical Education, 1000 North Oak Ave, Marshfield, WI 54449; ph 715/387-9207.1/88

Wisconsin Specialty Society Meetings 1988

- Wisconsin Chapter-American Academy of Pediatrics Annual Meeting, American Club, Kohler, April 22, 1988.
- Wisconsin Radiological Society and the Milwaukee Roentgen Ray Society, June 3-4, 1988, American Club, Kohler.
- Wisconsin Academy of Family Physicians, June 16-19, 1988, Holiday Inn, Stevens Point.
- Wisconsin Society of Obstetrics and Gynecology, July 21-23, 1988, Landmark Resort, Egg Harbor.
- Wisconsin Society of Anesthesiologists, Sept 9-11, 1988, Convention Center/Embassy Suites, Green Bay.
- Wisconsin Society of Internal Medicine, Sept 15-17, 1988, Milwaukee Marriott.
- Wisconsin Radiological Society, Sept 30-Oct 1, 1988, Concourse Hotel, Madison.

* * *

Specialty Society Meetings to be held in conjunction with SMS Annual Meeting, April 28-30, 1988, Milwaukee

- Wisconsin Allergy Society
- Wisconsin Society of Anesthesiologists
- Wisconsin Chapter, American College of Emergency Physicians.
- Wisconsin Academy of Family Physicians
- Wisconsin Society of Pathologists
- Wisconsin Society of Physical Medicine and Rehabilitation
- Wisconsin Society of Radiation Oncologists

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

WISCONSIN

APRIL 8, 1988: *Fourth Annual Duluth Heart Conference.* Sponsored by The Duluth Clinic, Ltd, and St Mary's Medical Center. Credits: AMA Category I, 6 hours; AAFP prescribed, 6 hours. Info: Barb Jablonski, Duluth Clinic Administration, 400 East Third St, Duluth, MN 55805; ph 218/722-8364, ext 710. 1-3/88

AUGUST 3-8, 1988: *"International Doctors In Alcoholics Anonymous,* Stouffer Hotel, Baltimore, MD. Info: Information Secretary, IDAA, 1950 Volney Rd, Youngstown, OH 44511; ph 216/782-6216. g1-7/88

AMA

JUNE 26-30, 1988: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 4-7, 1988: Interim House of Delegates, Dallas, TX.

JUNE 18-22, 1989: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 3-6, 1989: Interim House of Delegates, Honolulu, HI.

JUNE 24-28, 1990: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 2-5, 1990: Interim House of Delegates, Orlando, FL.■

State Medical Society of Wisconsin

Dates and locations of ANNUAL MEETINGS 1988-1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel, unless otherwise indicated.

1988—April 28-30
1989—April 13-15
1990—April 26-28: ***Green Bay***
Convention Center, Embassy Suites
1991—April 18-20
1992—April 23-25

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

BOOKS RECEIVED

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, William S Middleton Memorial Medical Library, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

The Age of Miracles. By Guy Williams. Academy Chicago, Publishers, 425 North Michigan Ave, Chicago, IL 60611. 1987. Pp 234. Price: $16.95.

An Emergency War Plan to fight AIDS and other Pandemics. Prepared by the EIR Biological Holocaust Task Force. 1986. Executive Intelligence Review, PO Box 17390, Washington, DC 20041-0390. Pp 138. Price: $250.

1986-1987 Source Book of Health Insurance Data. Prepared by the Public Relations Division of the Health Insurance Association of America, 1001 Pennsylvania Ave, NW, Washington, DC 20004-2599. 1987. Pp 96.

Manual for Eye Examination and Diagnosis. By Mark W Leitman, MD. Medical Economics Books, Oradell, New Jersey 07649. 1987. Pp 96. Price: $18.95.

Advancing Justice: May We Approach the Bench? Alliance of American Insurers, 1501 Woodfield Rd, Ste 400 West, Schaumburg, IL 60195-4980. 1987. Pp 100.

Catalog for the Health Care Management Professional—1987—1988. National Health Publishing, 99 Painters Mill Rd, Owings Mill, MD 21117. 1987.

Choices For A Healthy Heart. By Joseph Piscatella. Workman Publishing Company, Inc, 1 West 39 St, New York, NY 10018. 1987. Pp 580. Price: $14.95.■

AIDS and the IV Drug User

Training programs for alcohol and other drug abuse counselors

Sponsored by the Wisconsin Office of Alcohol and Other Drug Abuse (OAODA)

After completing this three-day course counselors will have a fundamental knowledge of HIV infections, AIDS, and AIDS-related complex and their attendant problems/challenges; be able to integrate information into treatment protocols; know of existing community resources and develop continued networking with others in the group.

Registration limited to 25 persons (maximum) per training event.

Program schedule:

#5 January 25-27, 1988: Milwaukee, The Red Carpet Inn (414) 481-8000.

#6 January 28-30, 1988: Milwaukee, The Red Carpet Inn (414) 481-8000.

#7 February 22-24, 1988: La Crosse, The Radisson Hotel (608) 784-6680.

Registration (with further info) no later than three weeks prior to the training event to: Deborah J Powers (608/266-7793), Project Coordinator, Division of Community Services, OAODA, Room 434, PO Box 7851, Madison, WI 53707-7851.

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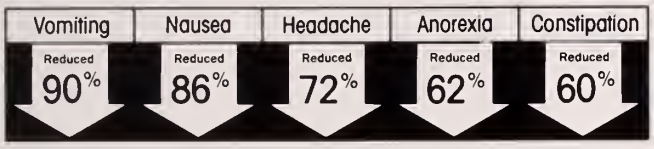

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References: 1. Feighner JP, *et al Psychopharmacology 61* 217-225, Mar 22, 1979 **2.** Data on file, Hoffmann-La Roche Inc , Nutley, NJ

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Before prescribing, please consult complete product information, a summary of which follows:
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Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses Myocardial infarction and stroke reported with use of this class of drugs) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e g , operating machinery, driving)

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide)
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients Periodic liver function tests and blood counts are recommended during prolonged treatment Amitriptyline component may block action of guanethidine or similar antihypertensives When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated, sedative effects may be additive Discontinue several days before surgery Limit concomitant administration of ECT to essential treatment See Warnings for precautions about pregnancy Limbitrol should not be taken during the nursing period Not recommended in children under 12 In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects
Adverse Reactions: Most frequently reported are those associated with either component alone drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs.
Cardiovascular Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke
Psychiatric Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido
Neurologic Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns
Anticholinergic Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract
Allergic Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus
Hematologic Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia
Gastrointestinal Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue
Endocrine Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion
Other Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling
Overdosage: Immediately hospitalize patient suspected of having taken an overdose Treatment is symptomatic and supportive I V administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning See complete product information for manifestation and treatment
Dosage: Individualize according to symptom severity and patient response Reduce to smallest effective dosage when satisfactory response is obtained Larger portion of daily dose may be taken at bedtime Single *h.s* dose may suffice for some patients. Lower dosages are recommended for the elderly Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses
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Official Publication of the State Medical Society of Wisconsin

WISCONSIN MEDICAL JOURNAL

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V. 87, NO. 2

Rural health initiative nears completion . . . One of President Viste's prime objectives during his term was the creation of a Task Force on Rural Health. As chairman of this task force, Doctor Viste traveled the state extensively to gather a consensus of the problems confronting rural physicians. He outlines them in his President's Page (see page 5).

Children's toys . . . Editorial Associate Lamont provides a thoughtful essay on the ability of parents to impart their moral and ethical values to their children and the physician's role in doing all he or she can to support and encourage parents in the very difficult job they have set for themselves (see page 8).

Voluntary active euthanasia . . . Editorial Associate Mullooly calls attention to the resolution introduced by the California delegates to the AMA at its interim meeting during which the AMA adopted a position to "oppose the enactment of any state or federal legislation that would require a physician to participate in, or advise a patient how to pursue a course of suicide, or would require an unwilling physician to refer the patient to a physician who would be willing to do so" (see page 9).

Rural Health Task Force Report . . . **forwarded to House of Delegates** contains a summary of the Task Force recommendations on physician manpower concerns, hospital and physician payment differentials, and health care delivery as a rural development strategy. The report will be introduced in the House of Delegates Session at the SMS Annual Meeting April 28–30 in Milwaukee (see page 35 [1]).

FEBRUARY 1988

WISCONSIN MEDICAL JOURNAL

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THE STATE MEDICAL SOCIETY OF WISCONSIN, created by the Territorial Legislature in 1841, represents over 6700 member physicians in Wisconsin, comprising 55 county medical societies and 28 medical specialty sections. The purpose of the Society is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society include continuing medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, services for physicians, operation of a Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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Kenneth M Viste Jr, MD

Rural health initiative nears completion

THE CREATION OF A Task Force on Rural Health was one of my three prime objectives when I became president of the State Medical Society in April 1987. Since its formation last summer, the Task Force and its various work groups met four times prior to the January 1988 meeting of the Board of Directors. Our job now is to seek approval of the final report and recommendations by the House of Delegates at the Annual Meeting April 28–30 in Milwaukee. The report and recommendations, as approved by the Board of Directors, appear elsewhere in this issue.

As chairman of the Task Force, and one who is deeply concerned about health care in rural Wisconsin, I take special pride in what we accomplished over such a short period. We have not answered all of the questions, but we have pointed to the direction that future efforts must go to address the challenges, problems and concerns confronting rural health care in Wisconsin.

One of our first activities as Task Force members was to mail a survey to physicians whose practices can be termed as predominantly rural in character. Of more than 1,300 surveys mailed, a total of 423 responses were returned and tabulated for an overall response rate of 32%. The survey results, in some cases, confirmed our suspicions. They also gave us direction and helped to set priorities for our work on the Task Force. The survey results reflected the concerns of our rural members and the strong dedication and spirit which they have given to our profession.

One physician, for example, wrote on the problem of physician recruitment, urging rural rotations for medical residents. He spoke of students who go through their training "without ever experiencing the practice of medicine without a CT scanner or cardiologist down the hall." This letter described the advantages of a rural practice, namely, more physician independence, better patient relationships and appreciation, and "the special pleasure in filling a void in medical care rather than fighting for part of the market." The physician's poignant remarks reflect the kind of positive image-building that rural health care needs to attract new faces and new commitments.

While many studies predict an oversupply of physicians, the need for more rural doctors persists. This was confirmed by the survey results in which 71% of the respondents noted plans to recruit more physicians, mostly in family medicine. To improve physician recruitment and retention in rural areas, the Task Force recommended, among other things, the development of a rural primary care curriculum for medical students; a state loan forgiveness program for physicians who practice in shortage areas, similar to the National Health Services Corps; establishment of an Area Health Education Center; and a rural health support system to provide continuing medical education opportunities, office management assistance, and physician back-up support.

Another major set of Task Force recommendations was aimed at seeking a more equitable and

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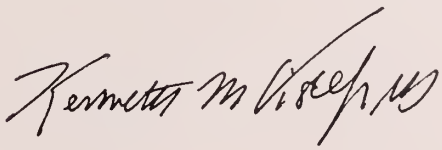

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realistic payment structure for rural physicians and hospitals under Medicare. Payment data reviewed by the Task Force showed reimbursement differences between some urban and rural physicians in excess of 40%, depending upon the procedure and area of the state. Similar disparities between urban and rural hospitals under Medicare's Prospective Payment System have already been well publicized. Current Medicare reimbursement policies, in fact, may be at least as effective in closing rural hospitals as the Hill-Burton Act was in constructing these same facilities!

Making problems worse, however, are the higher Medicare patient populations cared for by rural hospitals and physicians. Demographic data reviewed by the Task Force showed that counties with lower population densities had higher percentages of elderly, as well as lower median family incomes.

Rural populations are aging faster. Rural populations also tend to have larger percentages of uninsured and underinsured due to large numbers of rural workers who are self-employed, seasonally employed, or working in lower paying, full-time jobs.

These issues and affordability concerns were also reflected by the Task Force's survey results.

Nearly three-fourths of the physicians surveyed said they have seen a growth in the number of patients during the past five years who rely on government-subsidized health care. More than 60% noted marked increases in the amount of write-offs for uncompensated care during this time. About the same number of physicians indicated no change or a decrease in their incomes since 1982, despite working more hours in their practices. It is no small wonder that those responding to our survey viewed geographic variations in physician reimbursements as one of their chief concerns, second only to medical liability. Payment differences between urban and rural hospitals came in a close third.

While Task Force members recognized the need to reduce or eliminate these payment disparities and have recommended steps to educate policymakers and the public of these problems, they also agree that long-term solutions to rural health care concerns must be viewed in a far broader context in relation to rural development as a whole.

Rural hospitals are dependent upon strong community support and continued growth in the local economy. Likewise, these same local economies are dependent upon the continued presence of the community hospital and a viable rural health care delivery system.

The small community hospital is oftentimes the largest employer in the area—the heart of the local health care delivery system, and a major plus for attracting new physicians, as well as new business and industry to the area. People need to be reminded of this important interrelationship.

Although the Task Force on Rural Health urged steps to encourage more community-based approaches to rural health care delivery concerns, we have also recommended initiatives that state government could take to assist these local efforts. One is to develop options to strengthen capital financing help for health care facilities in chonically underserved areas. The Task Force also recommended a state planning grant program for pilot projects in underserved rural areas for the purpose of creating cooperative health care services programs and rural provider networks that would offer comprehensive primary care services to underserved populations.

Efforts by the National Rural Health Association, the National Association of Community Health Centers, the American Medical Association and many state organizations have helped to give rural health care issues a new prominence on the agendas of state and federal lawmakers. Now that the work of the SMS Task Force on Rural Health is nearly completed, it will be up to each of us to ensure that rural health care and rural development issues continue to receive the attention they truly deserve. We are a great state with an enviable health care system; we need to continue to be so. I believe that we have the ability and the resources to be a model in this endeavor.■

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Children's toys

ONE OF THE more interesting features of a holiday season is a wide variety of warnings that one receives. Most of these warnings are quite straightforward, such as those dealing with the care and feeding of the Christmas tree and those describing the consequences of inadvisedly indulging in a diet of holly berries, button batteries, and underdone turkey. Other warnings are less precise, both in their consequences and remedies. Among these are the warnings concerning the psychological impact of various toys on children.

War toys have been a special favorite for careful and often hostile analysis. Recently the arguments against such toys have gone beyond the nature of the toys themselves to the nature of their presentation to children. Many groups decry "program-length commercials," in which a particular toy is prominently employed throughout the program, and "interactive toys" which may produce or receive a signal from the television set, thereby allowing the toy and its user to participate in the television action.

The charges leveled at such toys are that they have the potential to promote violent and aggressive behavior, they exploit children as consumers, and they may tend to inhibit imaginative play and increase the intellectual passivity with which children view television. These charges are summarized in a recent news release from the American Academy of Pediatrics.

It has been suggested that legislation to ban or limit sales and advertising of war toys be proposed, and that research into the psychological effects of such toys on children be encouraged. While I feel very strongly that violent wanton behavior in children should not be encouraged, I find myself questioning this approach to the problem of controlling violent behavior.

Children have certain developmental needs. They have a need to fantasize about being stronger, more skillful, and more in control of their lives than they actually are. They have a need to learn right from wrong and to see good triumph over evil. They need to learn to control feelings of hostility, disappointment, frustration, and aggression. Finally, given their limited intellectual capacity, they need to have these needs met in a simple and straightforward way which they can understand. War toys, combat toys, etc tend to satisfy these needs very effectively. Such toys allow children to "act out" solutions to conflicts of good *vs* evil, right *vs* wrong in a way that allows the child to fantasize about being a superhero, and it allows him or her to vent feelings of aggression or anger in a way that does not hurt others.

In arguing the question of the effect of television on promoting violent behavior in children, it is worth remembering that the television generation really first appeared following World War II. It was this generation which, upon reaching college age, spearheaded the civil rights movement in the South, spearheaded the anti-Vietnam War movement, and now leads the fight for nuclear disarmament. While one may not agree with the propriety of these activities, one cannot question the fact that they are the products of the generation which supposedly grew up nurtured on television violence ranging from Roy Rogers to Highway Patrol to the Untouchables.

As for commercial exploitation, anyone who claims to have watched Davey Crockett without first putting on his coonskin cap, or the Mickey Mouse Club without putting on his Mouseketeer ears first, is a liar. Commercialization of television and the effect of children's television programs on toy-buying practices are nothing new. An effective argument against interactive toys is the cancellation argument, that is, should the show for which your toy was bought be cancelled, your toy becomes obsolete. Very likely, however, the laser pistol which can no longer be used interactively with the television will find its way out to the backyard where the child has converted a large packing box into a spaceship, and it will live out its life catering to the child's fantasy of being Captain Power or Luke Skywalker or some other latter day space intrepid.

As a society, we must remember that it is not possible to legislate a perfect world. The best and most effective laws are those which protect individual rights. Prohibitive legislation usually reflects a popular contemporary sentiment and as such stands the test of time very poorly and usually fails to achieve its desired result. The Volsted Act, Baby Doe legislation, and various local "blue laws," all reflect well-intentioned but misguided efforts to achieve better living through legislation.

As physicians, we should stress to parents the importance of their role as gatekeepers to the world of television. It must always be remembered that, as a commercial medium, television responds very acutely to what it perceives are the wants and desires of the viewing public. As

such, the best control over television is that control exerted in the marketplace. No legislation was necessary to cause CBS to cancel plans to air a television series based on the "Garbage Pail Kids." Public outcry was more than sufficient to achieve the desired result. This would suggest that the public is quite well able to recognize that which is truly repulsive and without merit, and deal with it accordingly.

Parents have the responsibility to impart their moral and ethical values to their children. It must be remembered that an ill-conceived law, once enacted, becomes a millstone about the public's neck for decades to come. The commercial television industry, on the other hand, is acutely sensitive to the whims of the public. Experience has shown that it will respond to the well-written letter of outrage from a concerned parent. In the meantime, however objectionable television programming may be, we do not yet live in an Orwellian world where television cannot be turned off at will.

The demand for legislation to control the content of children's television suggests that many parents are unable or unwilling to provide guidance for their children when it comes to television viewing. What will happen when the questions facing these parents deal not with television, but with drugs and sex—will they similarly abdicate their responsibilities?

The best defense against the ills of society is moral and ethical strength in the individual. That strength must be imparted in childhood. As physicians, we should be doing all we can to support and encourage parents in the very difficult job they have set for themselves.

—Jeffrey H Lamont, MD, Wausau

Voluntary active euthanasia

AS HAS BEEN reported in previous editorials, the citizens of California will be faced with a referendum in 1988 on a proposal to legalize voluntary active euthanasia. The California Bar Association House of Delegates has endorsed the proposal, but the California Medical Association has gone on record as opposing it. In so doing, the physicians of the CMA are upholding their Hippocratic Oath to do no harm. At our recent meeting of the House of Delegates of the American Medical Association, held in Atlanta, the California delegates introduced the following resolution on voluntary active euthanasia:

"WHEREAS, A philosophical and political movement to legalize voluntary active euthanasia (assisted suicide) for terminally ill patients is

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growing in many parts of the nation; and

"WHEREAS, Legislative proposals have circulated that would involve physicians in the administration of this activity and request a physician, if unwilling to participate, to effect the transfer of a patient who requests assistance in committing suicide to a physician who would participate, and

"WHEREAS, Many physicians may equate such a referral with aiding and abetting an act they consider ill-advised, unethical or morally repugnant; and

"WHEREAS, The primary role of the physician is to promote healing and the preservation and improvement of the quality of life; therefore be it

"*Resolved*, That the American Medical Association oppose the enactment of any type of federal or state legislation that would require a physician to provide the medicines, techniques or advice necessary for a patient to pursue a course of suicide or which would require a physician who is unwilling to participate in suicide to refer a patient to another physician willing to do so."

In response to California, the House of Delegates of the AMA at its Interim Meeting in December 1987 adopted the following policy:

"Resolution 79 asks that AMA oppose the enactment of any state or federal legislation that would require a physician to participate in, or advise a patient how to pursue a course of suicide, or would require an unwilling physician to refer the patient to a physician who would be willing to do so.

"At the 1973 Interim Meeting and again at the 1977 Annual Meeting, the House of Delegates adopted a clear policy that states:

"The intentional termination of the life of one human being by another—mercy killing or euthanasia—is contrary to that for which the medical profession stands and is contrary to the policy of the AMA."

It is refreshing for physicians to see the AMA take such an unequivocal stand. It affirms our commitment to our Oath, our values, and our patients. It should serve as a clarion call to members of medical associations throughout the world to rededicate themselves to their highest ethical tenet—to do no harm—and as a warning to all advocates of active euthanasia that the medical profession will not be used to implement their misguided desires.

—*John P Mullooly, MD,* Milwaukee■

Fiber supplement may lower cholesterol

A report in the February 1988 issue of *Archives of Internal Medicine* says an over-the-counter dietary fiber supplement may be as effective a cholesterol-lowering agent as some often-prescribed drugs. The study, by James W Anderson, MD, of the University of Kentucky, Lexington, and colleagues, involves psyllium hydrophilic mucilloid, a natural, soluble fiber derived from seed husks, by 26 men with mild to moderately elevated serum cholesterol levels (188 to 314 mg/dL). After eight weeks, the double-blind, placebo-controlled study found psyllium use lowered total serum cholesterol levels by 14.8 percent and cut levels of low-density lipoprotein by 20 percent. Psyllium treatment did not affect body weight, blood pressure or serum high-density lipoprotein levels. "Subject adherence to psyllium treatment was excellent, and no adverse effects were observed," say the authors of the study, supported by G D Searle & Co, Skokie, Ill, and the Proctor & Gamble Co, Cincinnati.—***AMA Brief Report***■

Serum iron in adolescent alcohol use

Alcohol use alters adult iron metabolism, predisposing to excess iron storage in the liver and possibly liver damage. Now, a study in the February 1988 issue of *American Journal of Diseases of Children, AJDC,* says adolescent alcohol users have elevated serum iron concentrations that increase incrementally with drinking frequency. Authors Ira M Friedman, MD, now of the University of California, Berkeley, and colleagues looked at drinking frequency and iron metabolism in 591 male and 614 female teenagers who took part in a national health survey in the 1970s. Alcohol had greater effects on iron metabolism in males than females; transferrin (an iron-transporting protein) saturation and hemoglobin concentration in the males paralleled their alcohol use. "These abnormalities may be precursors of hepatic iron overload and chronic liver damage," the authors conclude, saying more long-term research is needed.—***AMA Brief Report***■

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High-dose intravenous gamma globulin therapy for immune thrombocytopenia

Douglas Reding, MD, Marshfield, Wisconsin and *Mammo Amare, MD,* Kansas City, Kansas

ABSTRACT. *Between August 1983 and May 1984, we treated 11 patients (ages 16 to 85 years) who had idiopathic thrombocytopenic purpura (ITP), (four acute, seven chronic) with high-dose intravenous gamma globulin, 400 mg/kg/day for five days. Five patients had splenectomy and were refractory to conventional drugs; six had failed to respond to corticosteroids and had either refused or were unsuitable candidates for splenectomy. All patients were treated without ill effect, and all responded to therapy. Time to response was three to ten days and the mean platelet rise was 197,000/μl. Six patients had a sustained platelet count greater than 100,000/μl for three months or more. No relationship between previous splenectomy and the frequency or length of response was noted. The study confirms that high-dose intravenous gamma globulin is a safe and effective treatment in selected patients with ITP.*

Key words: Idiopathic thrombocytopenic purpura; Intravenous gamma globulin therapy; Prednisone; Platelet count

IDIOPATHIC thrombocytopenic purpura (ITP) is a clinical syndrome of undetermined etiology, characterized by a decreased number of circulating platelets and a normal or increased number of megakaryocytes. The majority of patients have platelet-associated immunoglobulin G (PA IgG). The mainstays of treatment are corticosteroids and splenectomy. Over 50% of patients who receive prednisone show initial improvement. Remission can be expected in 80% of patients who undergo splenectomy after becoming refractory to corticosteroids. Immunosuppressive drugs are usually reserved for patients who fail to have a satisfactory response to corticosteroids and/or splenectomy, and less than 30% of the patients show improvement.

In 1980, Imbach et al[1] observed that intravenous gamma globulin (IV IgG) improved the platelet count of two children with Wiskott-Aldrich syndrome that included agammaglobulinemia and thrombocytopenia. Subsequent studies by the same investigators and others[2,3] confirmed the beneficial effect of different brands of high-dose intravenous gamma globulin in some patients with immune-mediated thrombocytopenia. In this article we report our experience with consecutive adult patients, having ITP, who were treated with high-dose intravenous Sandoglobulin®.

At the time of this writing Doctor Reding was a Fellow, Division Hematology-Oncology, University of Kansas Medical Center, Kansas City, Kansas. He currently is in the Dept of Oncology, Marshfield Clinic, Marshfield. Doctor Amare is Professor, Dept of Internal Medicine (Hematology), University of Kansas Medical Center, 39th and Rainbow Blvd, Kansas City, KS 66103. Reprint requests to Doctor Amare at the above address. Copyright 1988 by the State Medical Society of Wisconsin.

MATERIALS AND METHODS.

Between October 1983 and November 1984, 11 adult patients with ITP were studied. Their clinical characteristics are listed in Table 1. Diagnosis of ITP was based on the presence of thrombocytopenia associated with normal or increased numbers of megakaryocytes in the bone marrow. All patients had platelet-associated antibodies demonstrated by flow cytometry.[4] Secondary immune thrombocytopenia and thrombocytopenia due to other causes were carefully excluded from clinical history and laboratory studies. Patient ages ranged from 17 to 87 years. Two were male and nine were female. Four had acute ITP (<6 months' duration), and seven had chronic ITP (>6 months' duration). All of the patients received prednisone prior to intravenous gammaglobulin therapy (IV IgG), and all were either refractory to or required high-dose prednisone to maintain an adequate platelet count. Five patients had prior splenectomy; six had either refused or were medically unfit for surgery.

IV IgG treatment: All patients received an "induction" course of Sandoglobulin®, 400 mg/kg intravenously over four to six hours daily for five consecutive days. Two patients who relapsed received a booster dose of 800 mg/kg as a single injection. The treatment protocol was approved by the University Hospital Human Subject Committee, and all patients signed informed consent.

Laboratory tests: Routine platelet counts were done by Coulter counter. For platelet counts lower than 50,000 μl, manual counts were done. Each sample was counted twice. The counts were done daily during treatment, followed by weekly counts for eight weeks, and monthly counts thereafter.

RESULTS. Table 2 summarizes the individual responses and current status of the 11 patients. All had substantial increases in their platelet counts. Mean platelet rise was 197,000/μl (range, 17,000 to 677,000) above the pretreatment level. The average platelet rise was 293,000/μl for the four acute and 163,000/μl for the seven chronic ITP patients. In both groups the platelet-count rise occurred as early as three days and reached its peak within ten days after starting treatment. The subsequent fall in the platelet count occurred at variable rate and was not related to the initial degree of response to therapy.

Three of the four patients with acute ITP showed sustained improvement, and one (Case 4) required maintenance with low-dose prednisone, 5 mg daily. Of the seven patients with chronic ITP, four (Cases 7,8,9,10) had a brief response lasting less than three weeks. Two of these patients (Cases 8,9) subsequently underwent splenectomy and had good response. Of the remaining two patients (Cases 7,10) who already had splenectomy, one (Case 10) received a booster dose of Sandoglobulin® and had a transient response lasting only three days. The other (Case 7) required maintenance therapy with prednisone. Three patients with chronic ITP had durable responses lasting at least three months. Of the two patients who had already had splenectomy (Cases 1,6) one (Case 1) relapsed at three months and received a booster dose of Sandoglobulin.® Her platelet count rose to 50,000/μl and remained stable for an additional 25 weeks. The other (Case 6) relapsed at six months and was maintained on prednisone, 10 mg/day. The third patient (Case 5) relapsed at five months and responded to subsequent splenectomy. Maintenance prednisone was resumed in patients who failed gamma globulin to obtain an average platelet count greater than 50,000/μl with treatment.

DISCUSSION. In recent years high-dose IV IgG has emerged as a useful agent in the treatment of patients with immune thrombocytopenia.[5,6] In our study 11 patients were treated with the "standard" regimen. We did not observe significant adverse effects of the drug, and response rates were comparable to results reported previously. While IV IgG is safe and has immediate therapeutic action, it is expensive and produces only transient response in a large proportion of patients. Thus, the drug should be used in clinical settings where it offers clear advantage.

Among patients with acute ITP, those with active bleeding stand to benefit most from IV IgG treatment. By raising the platelet count rapidly, IV IgG can eliminate the immediate danger of bleeding and may obviate the need for splenectomy in a few patients. Additional potential indications for IV IgG include the treatment of the pregnant woman with ITP and of the neonate with immune thrombocytopenia where administration of corticosteroids or splenectomy is not desirable.[7,8]

IV IgG may be an equally appropriate treatment for patients with chronic ITP who bleed while on high doses of corticosteroids. All our patients had good therapeutic effect, with normalization of the platelet count. In three who had bleeding from the gastrointestinal tract, immediate effective control was achieved. Indeed, IV IgG may be the only therapeutic option for patients with symptomatic ITP unresponsive to conventional therapy.

In a small proportion of these patients, a sustained platelet rise may result from intermittent administration of IV IgG. Our study findings in-

Table 1—*Patients' clinical data*

Case Number	*Age/Sex*	*Duration of ITP*	*Previous therapy*	*Splenectomy*	*Clinical indications for IV IgG*
1	36/F	5 yr	Prednisone Cytoxan® Vincristine	Yes	Steroid-induced psychosis
2	65/F	2.5 mo	Prednisone	Yes	Active duodenal bleeding
3	87/F	1 mo	Vincristine, weekly × 2	No	Melena
4	85/F	2.5 mo	Prednisone, 120 mg/day	No	Steroid-induced diabetes mellitus. Unable to tolerate splenectomy
5	17/F	2 yr	Prednisone	No	Menorrhagia. Refused splenectomy
6	80/F	4 yr	Prednisone	Yes	Hemoptysis and hematochezia
7	80/F	4 yr	Prednisone	Yes	Steroid-induced diabetes mellitus
8	64/F	4 yr	Prednisone	No	Unable to taper steroids. Refused splenectomy
9	76/M	2 yr	Prednisone	No	Hematuria
10	64/F	6 mo	Prednisone	Yes	Melena
11	23/M	2 mo	Prednisone	No	Refused splenectomy

ITP = idiopathic thrombocytopenic purpura; IV IgG = intravenous gamma globulin

dicate that prior splenectomy apparently does not influence the rate and duration of response. Moreover, the patients who had recurrence of thrombocytopenia following IV IgG treatment tended to require lower doses of prednisone to maintain an adequate platelet count (>30,000/μl).

Table 2—*Treatment outcome*

Case Number	*Platelet pretreatment*	*No./μl count posttreatment*	*Time to maximum platelet rise (days)*	*Remission duration*	*Current status*
1	17,000	158,000	3	3 mo	Booster of IV IgG at 12 wk. Platelet count maintained at 50,000 for 25 wk. Presently on low-dose prednisone.
2	100,000	677,000	3	26 mo	Off all medications
3	15,000	198,000	7	24 mo	Off all medications
4	51,000	81,000	6	6 wk	Maintained on prednisone 5 mg/day
5	149,000	169,000	5	5 mo	Splenectomy at 5 mo
6	11,000	399,000	6	6 mo	Maintained on prednisone
7	14,000	317,000	10	3 wk	Prednisone
8	30,000	103,000	3	3 wk	Prednisone followed by splenectomy
9	75,000	204,000	4	2 wk	Splenectomy
10	18,000	103,000	5	3 wk	No response to booster IV IgG. Splenectomy
11	11,000	312,000	10	15 mo	Off all treatment

SUMMARY. Our experience with a group of adult patients with ITP confirms the efficacy with safety of high-dose IV IgG for treatment of immune thrombocytopenia. The drug is particularly of advantage in controlling bleeding. Although its role is limited, it is useful in managing patients who are symptomatic from their disease or have major adverse effects from the conventional drugs (corticosteroids).

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Immunosuppression for cardiac transplantation at the University of Wisconsin–Madison

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ABSTRACT. *The increased success rate of heart transplants has stimulated an increase in the number of these procedures performed since 1985. The most recent results of cardiac transplant at the University of Wisconsin Hospital and Clinics are reported here, and our present immunosuppressive regimen is outlined. It is important that physicians be updated on the immunosuppression regimens used in cardiac transplant patients and acquainted with current followup trends so that both rejection and infection problems can be minimized at followup outside of transplant centers.*

Key words: Cardiac transportation, Immunosuppression; Transplantation

THERE HAS BEEN a striking increase in the number of cardiac transplants performed since 1985. The trend appears to be a reflection of the increasing success which many centers have with this procedure. In most large cardiac centers 80% of transplant patients may be expected to survive one year and 70% for five years.[1] The major reasons for

these dramatic improvements in survival rates are better procurement of organs and advances in immunosuppressive regimens.[2] This article describes the current immunosuppressive regimen that is used for patients at the University of Wisconsin Hospital and Clinics, the benefits and problems associated with this method, and the results we have obtained in cardiac transplant patients using this regimen.

During 1986, 15 cardiac transplants were performed at the University of Wisconsin Hospital and Clinics. There were no intraoperative deaths and 14 survivors, resulting in an early survival rate of 93%. Of the 15 patients in our series, 6 were females and 9 were males. Their ages ranged from 24 through 57 years with an average of 48. Three patients were on some type of circulatory assist prior to transplant (two patients with intra-aortic balloon counterpulsation and one patient with centrifugal pump ventricular assist). The remainder were patients selected for cardiac transplantation on the basis of an intensive evaluation. Of the 15 patients, 8 were found to have ischemic myopathies, and 5 had previous procedures (two valve replacements and three coronary artery bypass operations). Once selected for transplantation, the average waiting time to obtain a suitable donor organ was 20 days.

Our standard immunosuppressive regimen utilizes four drugs—prednisone, azathioprine, cyclosporine, and antilymphocyte globulin (ALG) [see Medication Comparison Chart].

The drug regimen is initiated immediately prior to the actual transplant (Phase I), individually adjusted according to defined guidelines after the transplant (Phase II), and further refined prior to discharge and at followup visits (Phase III).

During Phase I, we use preoperative laboratory values with particular attention to hematology and renal function studies to define which drugs can be given safely. Early in our series, all patients received preoperative cyclosporine orally, in doses ranging from 1–4 mg/kg. However, most of these patients showed significant increases in blood urea nitrogen (BUN) and creatinine. Now we give little or no cyclosporine preoperatively, with the selection of the exact dose, if any, based on preoperative creatinine, BUN, and creatinine clearance levels. Small doses of cyclosporine are given immediately after the transplant patient enters the intensive care unit (ICU). The dose is then serially adjusted according to whole blood RIA and HPLC levels and effects on BUN and creatinine. Likewise, if the white blood cell count (WBC) is normal, azathioprine is given in doses of 1.0–1.5 mg/kg immediately prior to transplant and adjusted according to the daily WBC counts. A bolus dose of 500 mg to 2 gm of Solu-Medrol® is given at the time of initiation of cardiopulmonary bypass and a subsequent dose of 500 mg is given 5 minutes prior to clamp release at the operating table. The steroids are then tapered on a schedule so that a dose of 30 mg/day is reached by day 14. ALG is given starting on the day following transplant, in most cases doses ranging from 10–15 mg/kg/day (platelets are given to keep counts above 100,000 during this period), and is continued daily until adequate levels of cyclosporine have been achieved, usually from 3–10 days.

MEDICATION COMPARISONS

	Method of action	*Time of use and dose*	*Side effects*
Antilymphocyte globulin (ALG)	Destroys T lymphocytes	10–15 mg/kg/day starting day after transplant (usually stopped by day 10 postop). Also for treatment of refractory rejection.	Infection Anaphylactic reaction Bleeding
Cyclosporine A	Inhibits T-cell function	Loading dose immediately prior to transplant 0–4 mg/kg depending upon preop renal function. Daily dose usually 2 to 10 mg/kg BID according to RIA or HPLC levels.	Hypertension Elevated blood urea nitrogen, creatinine (renal toxicity) Hepatic dysfunction Hirsutism Lymphoma Gum hyperplasia Tremors
Steroids	Suppresses T & B lymphocytes and inhibits motility of macrophages and leukocytes; vascular dilatation.	Bolus prior to transplant. Tapering dose over 2-week period. Approx 0.3 mg/kg/day first 6 months; Tapering to 0.2 mg/kg/day 6–9 months; Tapering to 0.13 mg/kg/day long-term.	Pancreatitis Infection (especially fungal) Gastrointestinal ulcers Cushinoid appearance Fragile skin Delayed wound healing Muscle weakness
Azathioprine	Antimetabolite which inhibits purine and DNA synthesis.	Loading dose 1.0–1.5 mg/kg-mediately before surgery. Then adjust according to WBC (try for dose of 1.0–1.5 mg/kg/day).	Infections—associated with leukopenia Bone marrow suppression Liver toxicity Nausea & vomiting Mouth sores

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In Phase II, post-transplant, our goal is to stabilize the levels of cyclosporine, azathioprine, and steroids. This is done by adjusting the whole blood cyclosporine levels to between 200-400 HPLC, 400-600 RIA, increasing the azathioprine to between 1.0-1.5, if the WBC will tolerate, and decreasing the steroids to approximately 0.3 mg/kg/day. All medications are adjusted according to the above parameters and the results of weekly endomyocardial biopsies. At final discharge, Phase III, usually at 3-4 weeks, the drug regimen is expected to be stable and the patient is self-administering azathioprine, prednisone, and cyclosporin A.

Serial endomyocardial biopsies are used to monitor the possibility of rejection and to establish the appropriate levels of immunosuppressive agents in the followup. Presently, our protocol is to biopsy weekly for the first eight weeks, then, if no rejection episodes intervene, biweekly until three months post-transplant, triweekly until six months post-transplant, monthly until one year post-transplant, then at six-month intervals for life. There was an average of 1.5 (±1.2) rejection episodes per patient at six months post-transplant. Only two patients had more than two rejection episodes (which never were above grade III/IV). Only one patient had a grade IV/IV rejection episode which required extended treatment. Our average of less than 1.0 rejection episode during the first three months post-transplant is quite favorable and we believe that this reflects the quality of our immunosuppressive regimen.

All patients survived the perioperative period and were transferred from the intensive care unit as early as the third post-transplant day. The single death in our series was a late consequence of anoxic brain damage secondary to an arrest from cardiac tamponade. Only one patient had a major complication, which was a life-threatening infection (a confirmed aspergillus pneumonitis with a presumed aspergillus brain abscess). Our 93% survival rate at time of discharge from transplant hospitalization is a major improvement from previous years and compares very favorably with that obtained in other centers. We feel that this improved survival rate relates largely to the judicious and flexible use of immunosuppressive drugs, close monitoring of drug levels and side effects, and frequent endomyocardial biopsies.

Summary. Currently, there are many centers now working to define the best method of immunosuppression for cardiac transplantation.[3] We are very pleased with the early success of our immunosuppressive regimen for cardiac transplant patients. Although the use of these agents in transplantation is not new, the combination, sequencing, and monitoring that we employ is unique. Over the long-term, we would like to reduce the steroid dose as low as possible and maintain the patient on a regimen of prednisone, cyclosporine, and azathioprine. However, because patients at other centers have suffered severe nephrotoxicity related to cyclosporine therapy, it may ultimately prove necessary to completely delete cyclosporine from the immunosuppressive regimen late in the post-transplant course of some patients.[4,7] It is our opinion that each patient is unique so that the proper drug management will depend upon each patient's individual response to the various drugs; therefore, flexibility must be maintained. The regimen of steroids, cyclosporine, azathioprine, and antilymphocyte globulin (ALG) that is delineated here appears to provide good success with immunosuppression while minimizing the adverse side effects of these drugs. However, since proper drug management ultimately depends upon each patient's individual response to various drugs, flexibility within this regimen is considered essential.

Sterilizer gas may affect hospital workers

A report in the December 1987 issue of *Archives of Neurology* suggests long-term, low-dose exposure to ethylene oxide, a gas widely used in sterilizing heat-sensitive materials, can cause neurologic problems, and that these effects may occur at exposure levels common in hospital sterilizer operations. William J Estrin, MD, of the University of California-San Francisco, and colleagues studied eight hospital employees with an average of 11.6 years working near ethylene oxide sterilizers and whose exposure was believed typical of the industry. Compared with eight controls, the exposed group performed more poorly on cognition, memory, attention and coordination tests. The authors say an estimated 75,000 health care workers are exposed to ethylene oxide annually. The gas is known to be toxic and exposure has been linked to neurologic problems in animals and humans, but the results of chronic, low-dose exposure had been unclear. The authors say typical workday exposure in hospitals generally averages less than 1 ppm—the current government limit.—***AMA Brief Report***■

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Head trauma and epilepsy

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ABSTRACT. *Car accidents and other causes of head injury each year produce a large population of patients who are at some risk for developing an epileptic seizure disorder. The risk of developing a seizure disorder, its eventual severity, and potential for prevention with the use of anticonvulsants are all practical issues that we share with our colleagues across the State of Wisconsin. This article is an attempt to develop some guidelines for these problems based on a review of the literature.*

Key words: Head trauma; Epilepsy prognosis; Post-traumatic seizures

An association between head injury and epilepsy has been suspected since Hippocratic times.[1] Trauma to the head may be divided into (1) closed or blunt and (2) penetrating. In both, the key interest focuses on the potential brain damage caused by blows to the head. Early consequences of impact injury include focal cerebral injury such as in contusion or hemorrhage, raised intracranial pressure, reduced cerebral perfusion, cerebral edema, and epileptic seizures. The late or delayed effects of severe brain injury also include post-traumatic epilepsy. Such epilepsy depends upon the extent of cortical damage and on the inherent susceptibility of the individual patient. Both the amount of localized cortical damage as well as the extent of diffuse damage (reflected in the duration of post-traumatic amnesia) may contribute to producing a potentially epileptogenic lesion.[2]

Clinical studies: Penetrating head injuries have been studied extensively in the war-injured. Post-traumatic epilepsy has been reported to occur in up to 45% of this group of patients.[2] A recent study regarding Viet Nam veterans has indicated that 53% of patients with penetrating head injury have post-traumatic epilepsy and approximately half of these patients continue to have seizures after 15 years.[3]

Factors other than penetrating brain injury associated with a heightened risk of post-traumatic epilepsy include loss of consciousness, post-traumatic amnesia for more than 24 hours, focal neurologic signs, early seizures (those that occur within one week of injury), depressed skull fractures, intracranial hematoma, and dural lacerations. When two or more of these factors are associated, the risk is higher.[4]

Non-missile, or blunt head trauma, as it relates to epilepsy has been studied most extensively by Jennett.[1] He has attempted to answer questions relating to early and late post-traumatic seizures and their prognosis, so that treatment can be initiated or withheld in an appropriate fashion. Guidelines also are needed to address medicolegal issues relating to disability, and to advise patients in terms of restricting their activities, such as driving, if they are at risk for seizures.

Seizures occurring soon after injury are often given a different significance than those occurring later. Jennett found that seizures occur more frequently during the first week after injury than during the next seven weeks. Furthermore, seizures that occur within one week of injury are less likely to recur than seizures beginning in the next few weeks. In this study a seizure was never the only or first sign of a developing intracranial hematoma, and less than 2% of patients who had early seizures proved to be developing an epidural hematoma at the time of the first seizure. Late epilepsy, or remote post-traumatic seizures, occurred significantly more often when there had been early seizures. The overall risk of late epilepsy in unselected blunt head trauma patients in Jennett's study was about 5%. This risk was increased by three factors—acute hematoma (31%), early seizures (25%), and depressed skull fracture (15%)—without these, the occurrence of late epilepsy was 1%. around 1%.

After depressed skull fracture, the incidence of late epilepsy varied from 4%–50%. Depressed skull fracture in a patient less than age 16 had lower risk. Depressed skull fracture plus post-traumatic amnesia of greater than 24 hours increased the risk to 33%. Addition of early seizures increased the risk to 66%.[1]

In 1980, a population study done at the Mayo Clinic involved 2,747 patients followed for 28,176 person years. Injuries were defined as severe (contusion, intracranial hematoma, or post-traumatic amnesia greater than 24 hours), moderate (skull fracture, or 30 minutes to 24 hours of post-traumatic amnesia), and mild (briefer post-traumatic amnesia). The risk of post-traumatic seizures was 7.1% within one year

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and 11.5% in five years in the severe group; 0.7% and 1.6% in the moderate group; and 0.1% and 0.6% in the mild group. The incidence of late post-traumatic epilepsy in the mild head injury group was not significantly different from the general population.

This study has varied from many previous studies in that all cases with loss of consciousness were studied whereas many other studies had looked only at patients who had actually been admitted to a hospital or examined by a neurosurgeon. Thus, other studies may have excluded many of the mildly injured patients. Some other studies also have included patients who had preexisting epilepsy. Yet other studies included many patients who presented with sequelae of head trauma such as seizures, thus being biased toward a higher incidence of post-traumatic epilepsy. In Jennett's study only 100 of 896 patients had mild head injury. The overall risk of 5% in that study may reflect more severely injured patients. Most other studies have revealed lower rates, 0.14%–2.7%.[5]

Jennett also found that seizure onset was less than one year after trauma in more than 50% of cases of late epilepsy; however, one patient in five had seizure onset more than four years following injury. Patients who had early as well as late epilepsy less often had the onset of late epilepsy after four years.[1]

Neurodiagnostic studies. In addition to clinical neurologic evaluation and consideration of epidemiologic information, what can be done in an individual patient to more clearly define that patient's risk for seizures? Electroencephalographic studies (EEG), which are helpful in diagnosis of epilepsy in general, have been disappointing in detecting those at risk for post-traumatic epilepsy. Jennett and van de Sande studied 722 patients with high risk of late epilepsy (43% did develop epilepsy). Although abnormal records were more common in patients who developed epilepsy, this reflected more severe brain injury which was already clinically evident. Twenty percent of patients with late epilepsy had at least one normal EEG in the first three months following injury. Some patients with persistent or newly developing EEG abnormalities never had a seizure. Jennett and van de Sande as well as Walton (1963), Courjon (1969), and Terespolsky (1972) all have concluded that EEG studies are not helpful in predicting post-traumatic epilepsy.[6]

More recently, computerized axial tomography (CT) as it relates to post-traumatic epilepsy has been studied. D'Alessandro, *et al* studied 233 head-injured patients. Forty-nine had at least one risk factor for post-traumatic epilepsy and 10 cases studied with CT developed late seizures. All 10 of these patients had CT abnormalities. Twenty-one patients, however, had focal CT abnormalities and did not develop late seizures during the three-to-five-year followup period. These authors concluded that an early CT scan abnormality is a risk factor for post-traumatic epilepsy and it may be possible to select patients for prophylactic anticonvulsant therapy on the basis of CT scan alone.[7]

Reisner, *et al* found that combined clinical neurologic evaluation, CT scan, and EEG studies yielded an abnormality in all but 3 of 64 patients with post-traumatic epilepsy. However, CT scan was normal in 22% and EEG studies were normal in 19%.[8]

Clinical management. Some data from animal as well as human studies suggest benefit from prophylactic administration of anticonvulsants. Clinical studies thus far present conflicting results.[9] Salazar, *et al* in a report of the Viet Nam head injury study, have looked at data regarding 421 patients with penetrating brain wounds. Treatment with phenytoin in the first year following injury did not prevent later seizures.[3] Young, *et al* reported results of a randomized double blind, placebo-controlled study of 41 patients. Phenytoin was instituted within 24 hours following trauma. Only patients estimated to have greater than 10% probability of late seizures were included. There was no significant difference in incidence of late post-traumatic epilepsy between the treatment and placebo group.[10]

McQueen *et al* studied 164 patients with severe head injury. They concluded that because of the low incidence of post-traumatic epilepsy, at least six times the number of patients they studied would be required to draw valid conclusions.[9]

Intimately related to the question of who should be treated is which patients should have their activities restricted. Driving is restricted in patients with established epilepsy. The patient who is known to be at increased risk for seizures but who has not developed a seizure disorder presents a more difficult situation. Some head-injured patients certainly fall into that category. More than 50% of head-injured patients who will develop seizures do so during the first year following trauma. It has therefore been suggested that such patients with an appreciable risk of post-traumatic epilepsy (*eg*, greater than 20%) be temporarily restricted from driving. Such patients may or may not be treated with anticonvulsants.[11] A survey in the United Kingdom has revealed that nearly 50% of neurosurgeons questioned felt that a risk of epilepsy of less than 10% justified stopping someone from driving a private vehicle.[12]

Conclusions. In summary, head trauma in general places patients at an increased risk for developing epilepsy. Severe penetrating head trauma results in a 45%–53% incidence of post-traumatic seizures. Severe blunt head trauma with an acute hematoma, prolonged post-traumatic amnesia, early epilepsy, and depressed skull fracture have a risk of late epilepsy which varies between 15% and 35%. When two of these factors occur in combination, the risk is greater.

There is no proof at this time that prophylactic administration of anticonvulsants prevents the occurrence of epilepsy. Mild head trauma carries at most a minimal increased risk of epilepsy and these patients do not require anticonvulsant medication unless epilepsy becomes clinically established. Electroencephalographic

studies are not helpful in predicting risk of post-traumatic seizures in an individual patient. CT scan may be helpful but further studies are needed. Treatment with anticonvulsants is indicated in established late post-traumatic epilepsy. Prophylactic treatment may be considered in high-risk patients but should be individualized. Not only the above scientific factors but also certain personal characteristics unique to each patient must be considered.

In general, restriction of patient activities such as driving should be based on factors similar to those used in deciding whether to administer anticonvulsant medications. However, in some individuals it may be reasonable to voluntarily restrict activities for a period while withholding anticonvulsant medication.

Formaldehyde's effects on mucous membranes and lungs

Formaldehyde, a key ingredient in the production of biochemical compounds and an important component of many commercial products, is a known irritant to the eyes, nose, throat and lungs. But there is debate about the concentrations needed to cause these reactions, and whether continuous exposure can cause chronic respiratory disease. A study of 109 industrial employees and 254 controls, published in the Feb 5, 1988 issue of the *Journal of the American Medical Association,* concludes that formaldehyde is a dose-dependent irritant of the eyes and mucous membranes at low levels of occupational exposure—well below 3 parts per million, the daily federal government limit at the time of the study. In addition, the chemical, "perhaps combined with other airborne substances, can exert a small (negative) effect on the airways as measured over the course of a work shift," says the report by Edward P Horvath Jr, MD, MPH, now of BP America, Inc, Cleveland, and colleagues. But even after an average exposure of 10 years, the authors conclude, "there is no evidence that it produces permanent respiratory impairment."—*AMA Brief Report*■

Rheumatic fever resurgence?

The incidence of acute rheumatic fever has plummeted in the United States over the past 50 years. Indeed, many doctors trained within the past two decades have never seen a case of the potentially devastating disease caused by a form of streptococcal bacteria. But an editorial in the Feb 5, 1988 issue of the *Journal of the American Medical Association* says a "new, equally surprising and highly disturbing chapter in the epidemiology of rheumatic fever may be in the making." Alan L Bisno, MD, of the University of Miami (Fla) and colleagues cite evidence that rheumatic fever may be making a comeback. They note reports of sizeable clusters of the disease in recent years in the Salt Lake City, Columbus and Akron, Ohio, and Pittsburgh areas, with anecdotal reports of increased numbers of cases elsewhere. The cause for this possible—though still spotty—resurgence is unclear, but the editorial suggests rare or especially virulent bacterial strains may be to blame. It calls for careful disease surveillance, saying doctors "must be aware that the beast is again afoot in the land and must assiduously employ the highly useful diagnostic and therapeutic tools at our disposal to protect our patients from the resurgent spectre of rheumatic fever and rheumatic heart disease."—*AMA Brief Report*■

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Screening for gestational diabetes in Central Wisconsin

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ABSTRACT. *It has been suggested that all pregnant patients be considered for gestational diabetes screening. Since the incidence of gestational diabetes in different patient populations varies considerably, different screening criteria may be appropriate for different populations. This paper evaluates the use of the O'Sullivan test and the three-hour glucose tolerance test as it applies to a Central Wisconsin population. The incidence of gestational diabetes among patients who are fully evaluated is 3.0%. Particular attention focuses on the issues of age of the patient and the value of the O'Sullivan test which indicates a need for a followup three-hour glucose tolerance test.*

Key words: Gestational diabetes; Glucose screening

GESTATIONAL DIABETES (GDM) is defined as an abnormality in glucose tolerance (metabolism) which becomes manifest during the present pregnancy.[1] Pregnancies complicated by gestational diabetes are at risk for increased fetal morbidity and mortality,[2] especially when associated with other recognized obstetrical risks such as hypertension, post-term gestation or previous poor obstetrical outcome. Mothers whose pregnancies are complicated by gestational diabetes are at an increased risk for development of maturity onset diabetes.[3,4] There also is increasing concern that the offspring of these pregnancies are at higher risks for obesity and diabetes themselves.[5,6]

Because of the immediate and long-term risks to both the parturient and her fetus, and because standard diabetes risk factors cannot be used to select patients for GDM screening,[4,7,8] the American Diabetes Association and American College of Obstetrics and Gynecology have recommended that *all* pregnancies be screened for gestational diabetes.[1] Considerable debate exists, however, regarding the optimum screening procedure considering both the accuracy of the screen and the cost-effectiveness of various screening parameters. Since there is a wide variation (0.15% to 12.3%[9,10]) in the incidence of GDM in different patient populations, it is essential that a decision on how to screen patients be based on data from similar patient groups.

This report details the results of a universally applied screening program for GDM in patients from the general population of Central Wisconsin whose pregnancy was monitored at the Marshfield Clinic. Specifically examined were the two most controversial areas of GDM screening: (1) the necessity of screening patients in younger age groups, and (2) what glucose value at the initial screen indicates the need for further evaluation.

Methodology. By agreeement with all practicing obstetricians at the Marshfield Clinic, the following protocol was established. All pregnancies, regardless of maternal age, were screened for gestational diabetes. Screening was done by design between 26 and 30 weeks gestation (additional testing was done at any time, if felt to be clinically indicated or if the patient registered late for pregnancy care, but only the screens at 26 to 30 weeks were included in this study). A 50-gm glucose screen was used in all patients according to the method of O'Sullivan.[2] Patients were not required to fast before the test. Screening plasma glucose values greater than 135 mg% led to the performance of a 100-gm, three-hour glucose tolerance test (GTT). The oral glucose tolerance test was performed following a three-day carbohydrate loading diet which insured a daily carbohydrate intake of at least 150 gm. During the actual GTT, patients were asked to rest quietly and refrain from smoking. A diagnosis of gestational diabetes was made if the GTT had two or more abnormal values. Threshold values were those suggested by the American Diabetes Association:[1] Fasting greater than or equal to 105 mg%, one hour greater than or equal to 190 mg%, two hour greater than or equal to 165 mg%, three hour greater than or equal to 145 mg%. All sugar determinations were done by standard laboratory techniques and did not use either chemstrips or glucose reflectance meters. Patients with an abnormal GTT were given the diagnosis of gestational diabetes and managed accordingly for the duration of their pregnancies.

Results. From Aug 1, 1985 to Sept 1, 1986 there were 891 patients screened for GDM. Two hundred and sixteen patients (24.2%) ex-

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ceeded the threshold level of 135 mg%, and were candidates for a three-hour oral GTT. Of these 216 candidates, 198 completed the GTT. The remainder failed to have the GTT because of early delivery, inability to tolerate the oral glucose solution, patient refusal or failure to follow the proposed protocol. Twenty-six (13.1%) of the 198 patients who completed a GTT were found to have an abnormal GTT according to the criteria described above. Table 1 summarizes these results. Thus, in our population, 3.0% of patients who were fully evaluated were found to have gestational diabetes by generally accepted criteria. This value may have been slightly higher if all 216 patients with positive O'Sullivan tests had completed a GTT.

Figure 1 shows the number of 50-gm glucose screens performed and the number of positive GTTs that resulted, grouped according to maternal age. Among mothers less than 24 years of age (a group Marquette[11] and others have considered not cost-effective to screen), 286 O'Sullivan screening tests were performed and 5 (1.7%) were found to have gestational diabetes.

Figure 2 shows the number of positive GTTs *v* total GTTs performed as it relates to the value of the O'Sullivan screen. In our population, 36 GTTs were performed for an O'Sullivan screen value between 136 mg% and 140 mg% (the threshold now recommended by the ADA[1]) and no abnormal GTTs resulted. It has been suggested[11] that 150 mg% is a more cost-effective threshold, and in our population for values between 141 mg% and 150 mg%, 76 GTTs were performed and 3 (3.9%) were abnormal.

Table 1—*Gestational diabetes screening results*

Total patients screened	= 891
Patients with O'Sullivan >135	= 216 (24.2%)
Number of GTTs performed	= 198 (91.7% of patients with an abnormal screen)
Number of patients with GDM	= 26 (3.0% of all patients who were fully evaluated and 13.1% of all GTTs performed)

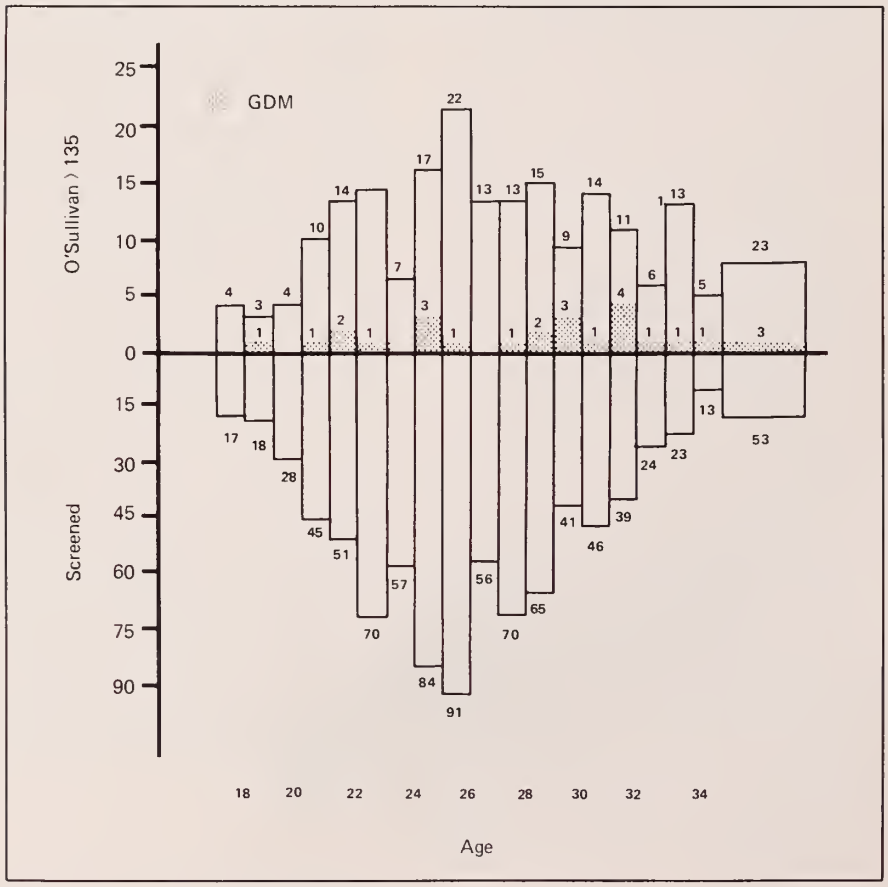

FIGURE 1—*Number of patients screened (lower bar graph) and number of those patients with abnormal O'Sullivan tests and GDM (upper bar graph) grouped according to patient's age. Hatched areas indicate patients with GDM. The wide bar at the right represents all patients age 35 or older.*

Discussion. Current recommendations suggest that all pregnant patients should be screened for gestational diabetes. These recommendations or guidelines, while generally accepted, contain considerable room for individual practice variation. Since the incidence of GDM varies widely depending upon the population studied, it is necessary for physicians to evaluate data from patient groups similar to their own practice populations. In considering the cost-effectiveness of GDM screening, most attention is centered on whether younger patients should be screened and on what value of the O'Sullivan test indicates the need for a GTT. Our evaluation of the O'Sullivan screening for GDM provides data pertinent to these two parameters.

For the population reported in this paper, we made the following determinations. (1) Our patients showed excellent acceptance of the O'Sullivan screen and compliance in those we recommended have a GTT. (2) The incidence of GDM was 3.0%, which is consistent with the national average but different from certain other patient populations. (3) As emphasized in Figure 1, no specific age group seems immune to the development of gestational diabetes, although the risk may be greater with advancing maternal age. Thus, we continue to recommend screening all

pregnant patients regardless of maternal age. (4) From Figure 2, however, it is clear that in our population the risk of gestational diabetes is very low if the O'Sullivan screen value is between 135 mg% and 140 mg%. Based on this, we have raised the threshold of the screening test from 135 mg% to 140 mg%. Although some false-negative screens will result, we feel that their rate will be acceptable at this higher threshold.

An additional consideration in determining the cost-effectiveness of GDM screening is that patients with GDM have a greatly increased risk of developing nongestational diabetes and their offspring may be at increased risk of developing obesity, gestational diabetes and nongestational diabetes. Whether there is a long-term benefit of identifying these patients remains to be seen, although it has been suggested[12] that interventions may be possible to reduce these risks. Finally, there is evidence that an elevated O'Sullivan screen itself, even in patients with normal GTTs, may have predictive value, especially for fetal macrosomia.[13] We are presently evaluating this possibility in our patient population.

ACKNOWLEDGMENT: The assistance of Susan Hayes, Susan Federwitz, and Debra Burr is greatly appreciated.

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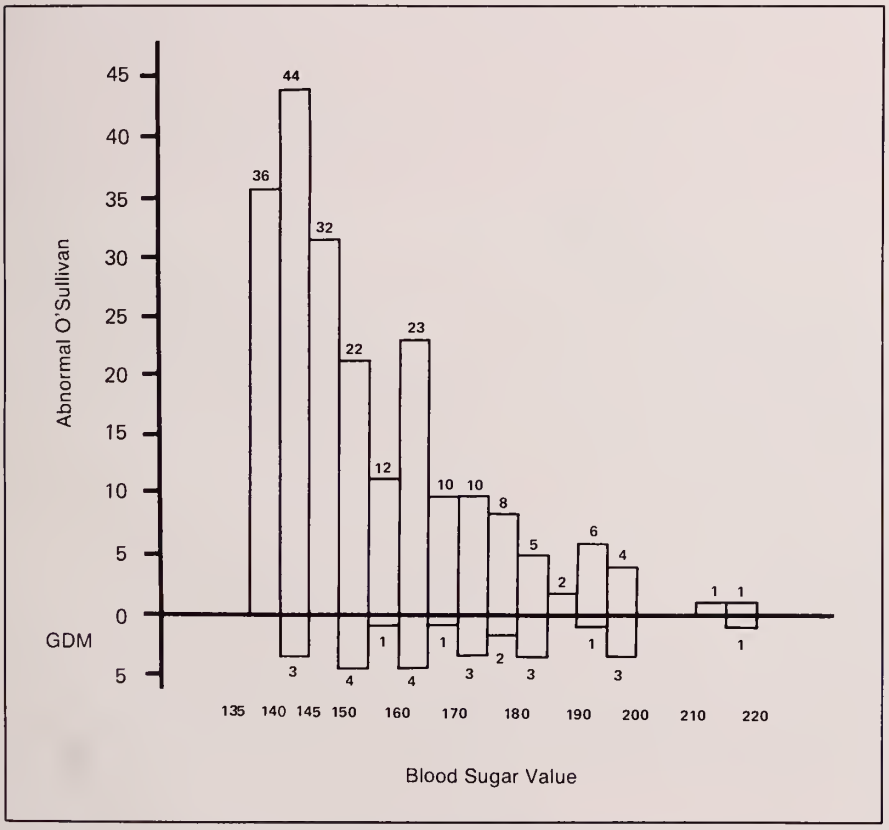

FIGURE 2—*Number of patients with abnormal O'Sullivan tests (upper bar graph) and number of those patients with GDM (lower bar graph) grouped according to value of the O'Sullivan screen.*

AMA to explore the issue of physician competence

The American Medical Association will cosponsor a national conference on "Physician Competence: Whose Responsibility?" April 7-9 at the Warwick Hotel in Houston.

This is the fourth in a series of conferences in which the AMA has joined with American Hospital Association and the Association of American Medical Colleges to explore common issues in healthcare.

Topics and invited speakers include:

- Role of state government: David Axelrod, MD, Commissioner of Health, New York State Department of Health
- Responsibility of the profession: Philip Lee, MD, Director, Institute for Health Policy Studies, University of California-San Francisco
- Competence assessment during medical school: Joseph Gonnella, MD, Dean and Vice President, Jefferson Medical College of Thomas Jefferson University

Those wishing further registration or program information should contact Ira Singer, 312/645-4655. Press coverage of this conference is invited. Reporters should contact Pat Clark at 312/645-4497 for assistance with credentials and interviews.■

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Board approves task force reports on Rural Health and AIDS

The Board of Directors of the State Medical Society met at SMS Headquarters Saturday, January 16, and addressed a lengthy agenda. The following are the major actions taken by the Board:

Patient Compensation Panel system. A Special Task Force of Past Presidents convened at SMS Headquarters Monday, January 11, to hear testimony regarding SMS policy on the reinstatement of a modified Patients Compensation Panel system. The Task Force reviewed written materials submitted by Herbert F Sandmire, MD, Green Bay, and the Committee on Medical Liability, and took testimony from Doctor Sandmire, William J Listwan, MD, West Bend, and Richard G Roberts, MD, Madison. After more than four hours of testimony and nearly two hours of deliberation, the task force formed recommendations for action by the Board. The following recommendations were approved:

1. The Society should continue to oppose reinstatement of a modified Patients Compensation Panel system.

2. The Society should closely monitor the new mediation system. The Board should undertake a thorough review of the success of mediation by December 1989.

3. The Society should immediately introduce legislation to lower the cap on noneconomic damages to $250,000. The Society should continue to support any initiatives of the Coalition for Fairness in Medical Litigation that may be introduced in the Legislature that conform to previously adopted House of Delegates policy.

AIDS. The Board approved the following recommendations from the Task Force on AIDS:

1. Regarding the care of HIV-positive patients in nursing homes and in home-care settings, the State Medical Society recognizes that this is an issue of a new category of patients who need healthcare, and urges all nursing homes and home-care agencies to move in the direction of being able to accept and care for people who are HIV-positive through the following steps:

> . . . Urge county medical societies and medical directors to actively work with the facilities to identify issues, set up programs and prepare for patients if necessary, and to provide general education.
>
> . . . Recommend that in-service and educational programs focus on:
>
> (1) the fears of those in the industry by supplying facts and facilitating discussion with a goal of resolving those fears;
>
> (2) factual information about the disease, its transmission, and appropriate infection control measures;
>
> (3) sharing experiences in developing the ability to care for patients including policies and procedures needed, public relations, dealing with boards of directors, and personnel policies;
>
> . . . Recommend in-service at two levels: state level programs to be developed for leadership staff, administrators, directors of nursing, and medical directors, and at the individual staff level;
>
> . . . Review Medicaid reimbursement criteria and offer revisions, if necessary, to provide adequate funding to these agencies and institutions for their services.

2. In recognition of the significant current and future costs associated with the treatment and care of patients with AIDS- and HIV-related diseases, SMS endorses efforts to assure that Wisconsin receives its appropriate share of any federal funding provided for the care and treatment of this patient population, as well as funding for research on AIDS and HIV.

continued next page

SMS House resolutions due February 24

Resolutions for consideration by the 1988 SMS House of Delegates must arrive at SMS offices no later than Feb 24, 1988. Notice of the resolution deadline was mailed in mid-January to SMS delegates and officers of county medical societies and specialty sections.

The House will meet April 28 and 29 during the Society's 1988 Annual Meeting in Milwaukee. All resolutions calling for studies, conferences, or other activities resulting in expense must include a fiscal note, which SMS will help prepare upon request.

A sponsor of each resolution must also attend reference committee hearings to provide any additional background material needed. SMS Secretary-General Manager Thomas L Adams urges members to submit their resolutions as early as possible for adequate distribution and consideration of printed materials. Officers and directors may submit resolutions later than the February 24 deadline.■

3. SMS urges that protections currently in place under Wisconsin law, which prohibit group healthcare insurers from individual underwriting of policies and withdrawing coverage from an individual diagnosed as having an AIDS or HIV-related disorder, as long as all other contractual policy conditions are met, be steadfastly maintained.

SMS further believes that these same requirements and protections should apply to employers who self-insure, as well as other group insurance mechanisms which might not be covered by current state law.

SMS encourages studies at the state and national level to determine how best to provide continuing health insurance coverage to individuals identified as HIV-positive or diagnosed as having AIDS- or HIV-related disorders.

4. The AIDS Task Force recommends adoption of the Aug 21, 1987, Centers for Disease Control *Guidelines on the Prevention of HIV Transmission in Healthcare Settings.*

5. The AIDS Task Force requests endorsement and/or cosponsorship of an educational conference scheduled by the Wisconsin Association of Homes and Services for the Aging.

Editor's note: The CDC guidelines and the AIDS Task Force *Interim Report #3* are both available from Ron Henrichs, SMS Division of Communications (800-362-9080 or 608-257-6781).

SMS 1988 Budget. The SMS Budget for 1988 was approved, as submitted by the Finance Committee, and forwarded to the House of Delegates for its action. The committee viewed 1988 as a year for consolidation of recent gains, completion of the work of several ongoing task forces and the year in which to lay the groundwork for a major new initiative in tort reform for implementation in 1989–1990. Modest inflationary increases are provided in the budget to allow approved Society activities to continue.

The capital budget reflects the committee's request to borrow approximately $1,200,000 to finance the renovation of SMS Headquarters, which was conceptually approved in October 1987. Due to the age and wear of numerous mechanical parts, the changing composition of the Staff, the greatly different activities of the Society that have developed since the Headquarters building was built in 1954, and the need to maintain the SMS investment in the property, the committee recommended that the renovation program proceed.

In summary, the Society continues to be in reasonable financial health, with the realization that there is a need for a dues increase to fund new programs mandated by the Board of Directors and House of Delegates.

Committee on Women Physicians. Noting that the Committee on Women Physicians had met its original goals, and that the remaining concerns addressed by the committee appear to be common to both male and female physicians (often young physicians), the Board of Directors approved dissolution of the committee.

Goals for 1988. The action of the Board of Directors' Executive Committee—in its recommendation for, and approval of, the commission and committee goals and priorities for 1988, and in its recommendation that the commissions and committees report back in one year—was approved by the Board.

Health Policy Agenda. The AMA's *Health Policy Agenda for the American People* was filed by the Board. The Board noted that, although it plans no major SMS initiatives based on the HPA, the document provides a valuable resource for SMS members and staff.

Editor's Note: Copies of the HPA are available from Kit Nimtz, SMS Division of Medical Policy and Practice (800-362-9080 or 608-257-6781).

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Dr O'Leary addresses Board

Dennis O'Leary, MD, president of the Joint Commission on Accreditation of Healthcare Organizations, addressed the Board of Directors at its January 16 meeting. Doctor O'Leary began by stating that quality is the major public policy healthcare issue in this country. In the 1980s, the resources to provide quality care became increasingly limited because of a major shift in the power equation between those who provide care and those who purchase care. Doctor O'Leary feels that, since healthcare costs are still climbing at a rate that seems to have no control, more radical changes are coming.

There are basically three methods for examining clinical information: case-based review, which is a product of the PSRO program; structure and function review, an assessment of the capacity of the facility to provide quality care; and statistical profiles such as the HCFA hospital mortality data releases. The Joint Commission uses the second method, but Doctor O'Leary emphasized that much research is being done in all three of these areas.

Doctor O'Leary outlined the Joint Commission's "Agenda for Change" which includes: identifying clinical indicators of care; developing organizational and management indicators; risk adjustment for severity of illness; development of an ongoing interactive relationship among the Joint Commission and the organizations it accredits; and establishing a clinical indicator process by marrying data to the quality assurance process set forth by the Joint Commission. The Joint Commission currently reviews 5,400 hospitals and 3,000 other organizations.

Doctor O'Leary feels that there must be changes in physicians' priorities. Commitment to quality, he said, must take precedence over mere development of clinical standards. Physicians have an opportunity to lead, and Doctor O'Leary intends to make the Joint Commission one of the leaders.■

Impaired Physician Program. The Board referred to the House of Delegates the decision of whether to raise dues by $15 to provide for a half-time medical director for the Impaired Physician Program. The report of the Finance Committee noted that the program is one of the best in the country.

SMS Strategic Plan. With minor changes to include the SMS Auxiliary, the Board approved the report of the Strategic Planning Committee, and sent it on to the House of Delegates for consideration. A full report of the SMS Strategic Plan will appear in the March issue of the *Wisconsin Medical Journal.*

Rural Health. Thirty-two recommendations of the Task Force on Rural Health, designed to improve delivery of medical care to rural Wisconsin, were approved by the Board and passed on to the House of Delegates for consideration. A full report of the Task Force on Rural Health appears elsewhere in this issue of the *Wisconsin Medical Journal.*

Continuing Medical Education. The State Medical Examining Board has noted that when physicians fail to complete, or to document that they have completed, the required 30 hours of CME every two years, only two remedies exist: a letter of reprimand to the physician or a 10-day suspension of the physician's license to practice medicine. The Board asked SMS to recommend a third remedy, somewhere between the first two.

The SMS Commission on Continuing Medical Education recommended, and the Board of Directors approved, that the following suggestion be forwarded to the State Medical Examining Board:

"Physicians who do not have the required documentation for continuing medical education credits when asked to produce them by the Medical Examining Board should be required to complete 30 hours over the next 6 months at a designated pre-approved location in addition to their 30 current required CME credits."

Legislation. The Board approved recommendations from the Physicians Alliance Commission on six bills pending in the State Legislature. For more detailed information on these bills, contact Terry Hottenroth or Don Lord, SMS Division of Public Affairs (800-362-9080 or 608-257-6781).

continued next page

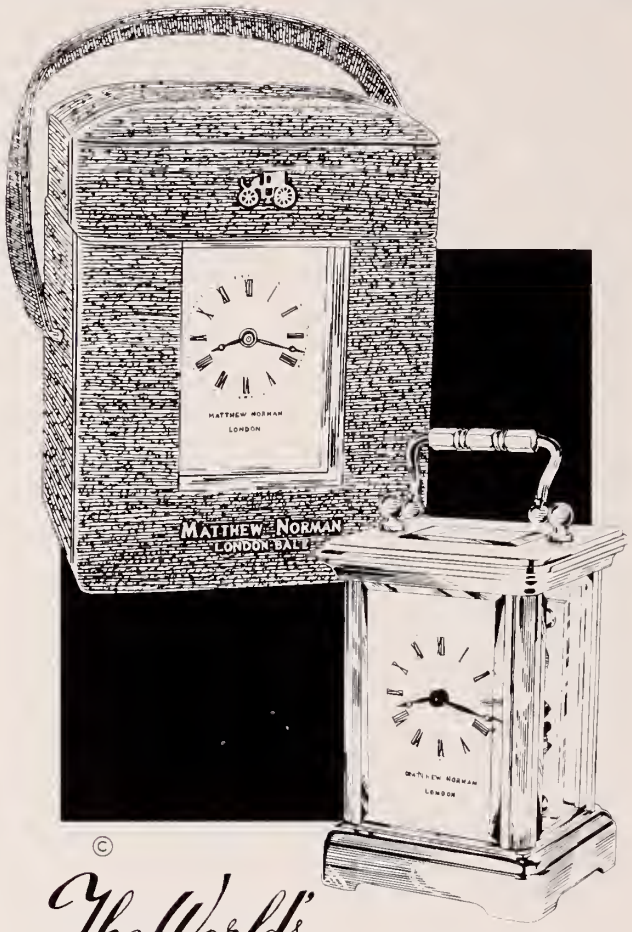
Gov Thompson, SMS Board of Directors discuss issues at breakfast gathering

Governor Tommy Thompson shows a willingness to work with the State Medical Society in capping noneconomic damages in medical malpractice suits, according to SMS President Kenneth M Viste Jr, MD. "It is obvious that the Governor wants to work with the Medical Society toward maintaining the finest healthcare system possible in Wisconsin," Doctor Viste said.

Doctor Viste's remarks came after the Board of Directors joined the Governor for breakfast at the executive residence in Madison, January 16. The Board discussed a number of issues with Governor Thompson, including tort reform, the SMS Impaired Physician Program, PartnerCare, SMS initiatives in rural healthcare, and the general improvement of the Governor's relationship with the Society.

Doctor Viste said the meeting was constructive, and that the Governor indicated that an excellent healthcare system was an integral part of his efforts to improve Wisconsin's image as a great place to live and work.■

FOOD FOR THOUGHT AT BREAKFAST. Gov Tommy G Thompson (standing) addresses the SMS Board of Directors following a breakfast at the executive residence. The occasion preceded the Board of Directors meeting Saturday, January 16, at SMS Headquarters. (Staff photo by Mark Adams)



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The Board also approved a recommendation of the Committee on Federal Legislation to support the AMA's Health Protection Act of 1987, which would prohibit advertising or other promotion of tobacco products.

Drug testing. The Board approved a report from the Committee on Alcoholism and Other Drug Abuse, which urged the SMS to adopt a policy condemning indiscriminate testing for drugs by employers or potential employers, and to include in such a policy clear guidelines on the limitations of urine testing to provide clinically valid information.

The committee's report also urged the State of Wisconsin to "seriously consider specially licensing and regulating laboratories which perform either screening or confirmatory tests."

Duty to warn. The Board approved a recommendation of the Mental Health Committee to support introduction and passage of legislation in Wisconsin, specifying the "duty to warn" principles evolving from the Tarasoff decision of the California Supreme Court.■

HIV tips available

Copies of the "Recommendations for Prevention of HIV Transmission in Health-Care Settings," published by the CDC in the Aug 21, 1987, supplement to the *Morbidity and Mortality Weekly Report,* are available from Ron Henrichs, SMS Division of Communications (800-362-9080 or 608-257-6781).■

Final Report: Task Force on Rural Health . . .

appears in this issue starting on page 35 (1).

Physicians are encouraged to review this important report which is being presented to the House of Delegates at the 1988 Annual Meeting, April 28–30 in Milwaukee.

PartnerCare: A work in progress

A rejuvenated social program with a statewide focus emerged as the most significant SMS project in 1987. PartnerCare's auspicious debut at the Society Annual Meeting last March made headlines in the Milwaukee major dailies, and set the stage for a wave of favorable state and national reviews.

Designed as a voluntary Medicare assignment program for low-income elderly, PartnerCare aims to increase access to needed medical care for seniors experiencing financial difficulties. SMS and the Coalition of Wisconsin Aging Groups served as chief architects of PartnerCare, and continue to oversee its introduction across Wisconsin. Fully one-third of all Wisconsin counties began participating in the program by January 1988 (see accompanying map). The rest of the state is expected to follow suit by April.

SMS President Kenneth M Viste Jr, MD, made PartnerCare's development and implementation the cornerstone of his platform for 1987–1988. Doctor Viste spoke and wrote extensively on PartnerCare and promoted the program at numerous county medical society meetings across the state. Likewise, the SMS medical society relations staff worked to introduce PartnerCare throughout the various field districts. Coalition staff, including several VISTA (Volunteers in Service to America) representatives, performed a parallel service by eliciting support from county offices on aging and local aging groups.

"Physician and clinic reaction to PartnerCare has been quite positive in most areas. It made our job a lot easier," said Doctor Viste. "We're heading into the home stretch now as we move toward our April 1988 target date."■

Ms Derene

Mr King

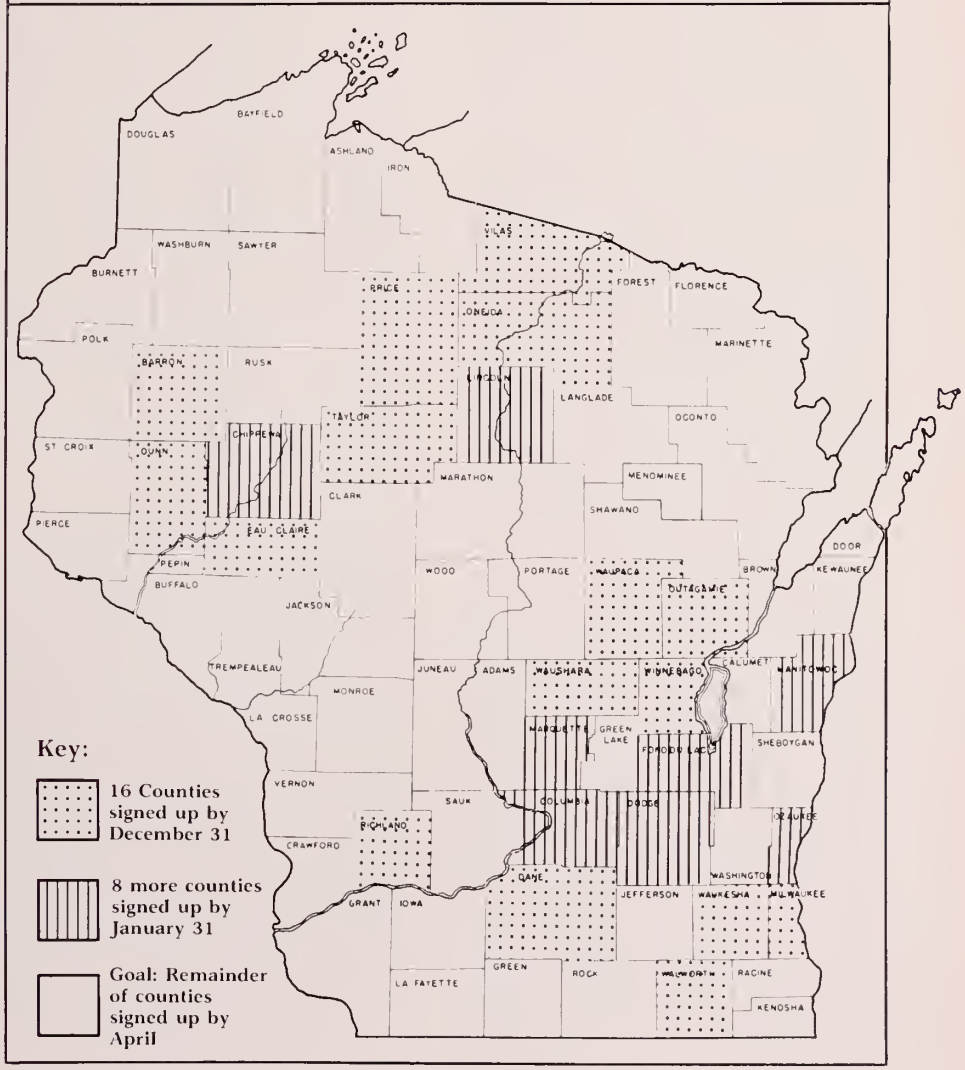
New Staff additions; Communications Division

Ron Henrichs, director of the State Medical Society's Communications Division, has announced the addition of two new Staff members.

Russell King joined the Staff in January as Publications Manager. He will assume responsibility for the *Wisconsin Medical Journal* and *Medigram* after the April retirement of Managing Editor Mary Angell. Mr King has been employed by the Wisconsin Grocers Association as editor of *Wisconsin Grocer* magazine. He holds a BA in journalism from San Diego State University.

Kathryn Derene joined the Staff in February as Publications Assistant. She will assist Mr King and Mr Henrichs in the SMS communications and public relations efforts. Ms Derene has been employed by the University of Wisconsin–Madison Department of Anesthesiology as the managing editor of *The Journal of Pain and Symptom Management*. She holds a BA in English from the University of Wisconsin–Madison.■

24 Counties signed up for PartnerCare



ANNUAL MEETING

Here is a slate of those candidates chosen for top State Medical Society offices by the Nominating Committee of the House of Delegates. This is the slate on which the House will vote at the Society's Annual Meeting March 28-30 at the MECCA in Milwaukee. The Bylaws provide that additional nominations may be made by members of the House at the time of elections on March 29.

Nominees for SMS offices; election March 29

Doctor Treacy

Doctor Foley

Doctor Hetsko

Doctor Stuff

William L Treacy, MD

President-elect, SMS (1988-1989)

Graduated from Marquette University School of Medicine (Medical College of Wisconsin) in 1957. An internist-rheumatologist, he served his internship at St Joseph's Hospital, Milwaukee, from 1957-1958 in St Paul, Minnesota, and his residency from 1958-1961 at the Mayo Clinic in Rochester, Minnesota. Licensed to practice medicine in Wisconsin in 1959, Doctor Treacy is a past president of the Wisconsin Society of Internal Medicine and a former chairman of the Department of Internal Medicine at St Joseph's Hospital in Milwaukee. He has been an active member of organized medicine since 1961, serving as a District 1 Delegate to the SMS from 1976 to the present. He was a member of the SMS Physicians Alliance Commission from 1979-1983, representing the Wisconsin Society of Internal Medicine; he also served on the Physicians Alliance Committee of the Medical Society of Milwaukee County, 1978-1981. He serves as board chairman of WISPAC (Wisconsin Physicians Political Action Committee) and is a member of the SMS Medical Liability Committee.

Cyril M Hetsko, MD

Vice Speaker, House of Delegates (1988-1990)

A native of Montclair, New Jersey, Doctor Hetsko graduated from University of Rochester Medical School, Rochester, New York, 1968. Internship and residency completed at University of Wisconsin Hospitals, Madison. Served in United States Army Medical Corps from 1972-1975 at US Army Medical Research Institute of Infectious Diseases, Fort Detrick, Frederick, Maryland. Board-certified in Internal Medicine. Private practice from 1975 to present at Dean Medical Center, Madison. Clinical Associate Professor of Internal Medicine, University of Wisconsin Medical School, Madison, June 1975 to present. Served as councilor of the Wisconsin Society of Internal Medicine from 1982-1985 and currently serves as secretary-treasurer. Chairman of Department of Medicine, St Marys Hospital Medical Center, Madison, 1985 to present. In 1981, recipient of the Presidential Award of the Dane County Medical Society, Madison, for "exceptional devotion in the development and the functioning of the Dane County Health Maintenance Program." Served as chairman of Public Relations and Prepaid Health Plan committees of Dane County Medical Society. Elected from Second District to Board of Directors of State Medical Society of Wisconsin, 1979-1988. Member of SMS Finance Committee since 1979 and chairman, 1984 to 1987. Elected alternate delegate to AMA in 1983 for an unexpired term through 1984 and reelected 1985, 1986, 1987 & 1988. Serves as chairman of the SMS Task Force on AIDS. President of the Wisconsin Society of Internal Medicine, 1987-1988.

John J Foley, MD

Treasurer (1988-1989)

Graduated from Stritch School of Medicine, Chicago, 1956. Internship and residency completed at Milwaukee County General Hospital, 1956-1957 and 1959-1963. Served in the United States Air Force, 1957-1959. Licensed to practice medicine in Wisconsin, 1959. Certified by American Board of Surgery and fellow, American College of Surgeons. Is assistant clinical professor of surgery, Medical College of Wisconsin, Milwaukee. Past president, Milwaukee Academy of Surgery, 1984. Member, Milwaukee Surgical Society. Served as SMS Councilor (now Director) from District 1, 1972-1981, and as treasurer of SMS, 1981 to present. Served as *ex officio* member of SMS Finance Committee of the Board of Directors. Also member of the Board of Directors of SMS Services, Inc, and its treasurer.

Patricia J Stuff, MD

Delegate, AMA (1989 & 1990)

Graduate of Woman's Medical College. Completed internship at St Luke's Hospital, Chicago, IL, 1955 to 1956. Served residency at Sacred Heart Hospital, Yankton, SD, 1956 to 1957. Received license to practice medicine in Wisconsin in 1957. Began general practice of medicine in Bonduel same year. Has been delegate to State Medical Society of Wisconsin from Shawano County Medical Society, 1966-1973 and alternate delegate in 1977-1978. Became vice-speaker of House of Delegates in 1973 and speaker of House of Delegates, 1975-1977. Also has served as member of State Medical Society's Nominating Committee and as member and chairman of House of Delegates reference committees. Member of organized citizens' committee to form Wolf River Mental Health Clinic. Was on Board of Directors of Unified Health Services Board of Shawano and Waupaca counties. Is chairman of credentials committee of Shawano Community Hospital. Was recipient of "Woman of the Year" award by Shawano County Business and Professional Women's Association in 1971 and is listed in *Who's Who of American Women*. Serves as Adjunct Professor, University of Wisconsin-Oshkosh, 1975 to present. Member of SMS Ad Hoc Committee on Women's Health Issues, 1979. AMA alternate delegate 1976-1978 and AMA delegate 1979 to present. Appointed to chair AMA Ad Hoc Commit-

continued next page

tee on Women Physicians in Organized Medicine, September 1979. Chairman of SMS Committee on Women Physicians 1981 to 1988. Serves on Health Education Committee of Bonduel community schools 1987 to present and also on Shawano County Task Force on AIDS, 1987 to present. Served on AMA House of Delegates as Reference Committee chairman, member, and chief teller, 1979-1983.

Doctor Williams

Doctor Fons

Doctor Scott

John Kimball Scott, MD

Delegate, AMA (1989 & 1990)

Graduate of Ohio State University College of Medicine, 1954. Completed internship at White Cross Hospital, Columbus, Ohio, 1954-1955. Otolaryngology residency completed at University Hospitals, Columbus, Ohio, 1955-1958. Licensed to practice medicine in Wisconsin, 1958. Certified by American Board of Otolaryngology, 1959. Clinical Professor of Surgery (Otolaryngology) at the University of Wisconsin Medical School, Madison. On the medical staff of St Marys, Madison General, Methodist, and University hospitals, Madison. Preceptor for fourth-year residency program, Madison General Hospital. President of Dane County Medical Society, 1975. Delegate from Dane County Medical Society to the State Medical Society, 1972 to present. Alternate delegate to the AMA, 1977-1978; delegate to the AMA, 1979 to present. Vice Chairman of Wisconsin Delegation to AMA; member and chairman of AMA Reference Committee, 1981 and 1982. Member of State Medical Society Reference Committee, 1971 and 1982. Reference Committee Chairman, 1972 and 1973. Chairman of the State Medical Society Committee on Cancer from 1971 to its dissolution in 1979. Member, SMS Committee on Medicine and Religion. Secretary-treasurer of WISPAC, 1980 to present. National delegate to American Cancer Society since 1972; President, American Cancer Society, Wisconsin Chapter, 1972. President of the Wisconsin Otolaryngology Society, 1974. Fellow, American College of Surgeons, 1962; President, Wisconsin Chapter of the American College of Surgeons, 1977. Member of American Academy of Ophthalmology and Otolaryngology since 1961. Chairman, Commission on Cancer, Wisconsin Chapter of American College of Surgeons. Member, Society of Head and Neck Surgeons since 1963. Member, American Laryngological, Rhinological, and Otological Society since 1972. President WisPRO, 1976-1981. Team physician (ENT), West High School, Madison, and the University of Wisconsin. President of North Central Medical Conference, 1983-1984. Is Hospital Section member to AMA/Madison General Hospital. Was president-elect, SMS, 1984-1985, and served as president in 1985-1986. Served AMA House of Delegates as member of reference committee on "miscellaneous issues" at Interim Meeting in Washington, DC, December 1985 and also was named in 1985 to AMA's Council on Long Range Planning and Development.

DeLore Williams, MD

Delegate, AMA (1989 & 1990)

Graduate of the former Marquette University School of Medicine. Interned at Milwaukee's Columbia Hospital, 1948-1949, with residency training at VA Hospital, Milwaukee, 1949-1951 and 1953-1954. Licensed to practice medicine in Wisconsin, 1949. Prior to completing residency, served in the US Air Force. Certified by American Board of Internal Medicine, 1957. Practices in West Allis and is clinical instructor at Medical College of Wisconsin. Was chairman of SMS Ad Hoc Committee on Quackery. Served as 12th District and 1st District SMS Councilor (now Director), 1971-1977. Served on former Commission on Public Policy as regular member between 1971 and 1972 and ex officio member between 1973 and 1978. Was member of SMS Council's Finance Committee, 1971-1977. Member of SMS Physicians Alliance Commission since 1985; member of SMS Federal Legislation Committee, 1985; and was chairman of the Physicians Alliance Commission Ad Hoc Committee on the Uninsured, 1985-1987. Also member of Wisconsin Society of Internal Medicine, American College of Physicians, and American Society of Internal Medicine. Delegate to State Medical Society since 1972. Delegate to AMA, 1977-1988. Member of The Medical Society of Milwaukee County and served on Legislative Policy Committee, chairman for four years; served on county society's Editorial Board and Medical School Liaison Committee; and also served on Long-range Planning Committee three years, and Liaison for Medical Society of Milwaukee County to ShareCare and WisconCare. Served as member of West Allis Memorial Hospital's Board of Directors, and member of Finance Committee, Public Relations Committee, Quality Care Committee, and Long Range Planning Committee; also chairman of its Development Council.

Jerome W Fons Jr, MD

Alternate Delegate, AMA (1988)

Graduate of Marquette University School of Medicine, now Medical College of Wisconsin, in 1962. Served internship and residency at St Joseph's Hospital in Milwaukee from 1962-1966; in 1963 he received his license to practice medicine in Wisconsin. During 1954-1955, he served in the US Army Medical Corps in Alaska. An obstetrician-gynecologist, Doctor Fons is on the medical staff of Trinity Memorial Hospital, Cudahy, and St Francis Hospital, Milwaukee. He served as president of The Medical Society of Milwaukee County in 1985-1986. In 1986 he was named to the Board of Directors of the newly formed Physicians Insurance Company of Wisconsin and serves as its president. In 1984 he was named to the SMS Committee on Medical Liability of the Physicians Alliance Commission; he subsequently was named to the Task Force on Medical Liability which completed its task in 1986. Doctor Fons was elected to the SMS Board of Directors in 1981 to complete the unexpired term (1979-1982) of Paul G LaBissoniere, MD. He will be completing his second full three-year term at this year's Annual Meeting. A member of the State Medical Society of Wisconsin since 1964, he is married and has eight children.

Editor's note: Doctor Fons would be completing term (to end of 1988) of John D Riesch, MD, who was elected Delegate for the term (1988 & 1989) at the 1987 Annual Meeting to succeed Henry F Twelmeyer, MD. ■

Plan now to attend!

1988 ANNUAL MEETING

The State Medical Society of Wisconsin

"Family Health Concerns"

House of Delegates April 28–29
Scientific Programs April 28–29–30

Milwaukee Exposition & Convention Center & Arena (MECCA)
500 West Kilbourn Avenue
Milwaukee, WI 53203
414/271-4000

HEADQUARTERS HOTEL
Hyatt-Regency Milwaukee
333 West Kilbourn Avenue
Milwaukee, WI 53203
414/276-1234

Presented by the SMS Scientific Program Committee:
Kathy P Belgea, MD, Wausau, Chairman
Charles E Holmburg, MD, Madison, Co-Chairman
George Nemec Jr, MD, Woodruff, Co-Chairman
and the Commission on Continuing Medical Education

Edwin L Overholt, MD, La Crosse
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Victor S Ejercito, MD, Marshfield
C William Freeby, MD, Appleton
Bradley G Garber, MD, Osseo
Charles E Holmburg, MD, Madison
J David Lewis, MD, West Bend
Joseph J Mazza, MD, Marshfield
George Nemec Jr, MD, Woodruff
Lori L Neumann, MD, Darlington
Lee Richardson, MD, Green Bay
William M Toyoma, MD, Marshfield
Thomas L Zurbriggen, MD, La Crosse
Ed Zupanc, MD, Monroe
Dianne L Zwicke, MD, Milwaukee

Membership Directory—Update

The following information is being provided from Membership reports and from individual members for updating the 1987 Membership Directory as published in the July 1987 issue of the *Wisconsin Medical Journal.* Because of space limitations address changes and phone numbers will not be included in this Update; however, they will be changed in Membership Records. County transfers will be included when processing has been completed by Membership Records. **Changes in practice specialties** (as used by the AMA) and changes in **Board-certified specialties** as listed by the American Board of Medical Specialties (see July 1987 Membership Directory) are included. **Practice specialties** appear before the slash (/) and **Board-certified specialties** appear after the slash.

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continued next page

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Paul A Larson, MD
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BLUE BOOK/UPDATE

On page 177 the following changes for the Wisconsin Radiological Society are:

(October 1988)
P—Robert Durnin, MD
20 South Park St, #201
Madison, WI 53715

PE—Eric B Wilson, MD
4397 Country Club Rd
Oshkosh, WI 54901

VP—Paul Bolich, MD
1586 Arapahoe Ct
Green Bay, WI 54303.

On page 167 under the Physicians Alliance Commission, Edgar L Koch, MD, Kenosha, has resigned.

On page 176 under the Officers of Wisconsin Specialty Societies, the following changes have been made:

Wisconsin Allergy Society

(November 1989)
P—Robert K Bush, MD
6618 Dumont Road
Madison, WI 53711

PE—Martin J Voss, MD
733 West Clairemont Avenue
PO Box 1510
Eau Claire, WI 54702

ST—Martin Lobel, MD
324 East Wisconsin Avenue
Milwaukee, WI 53202

Wisconsin Society of Pathologists

(November 1989)
P—David J Rothwell, MD
2025 East Newport Avenue
Milwaukee, WI 53211

VP—Richard A Komorowski, MD
8700 West Wisconsin Avenue
Milwaukee, WI 53226

T—Jay F Schamberg, MD
S47 W22060 Lawnsdale
Waukesha, WI 53186

Wisconsin Society of Physical Medicine and Rehabilitation

(November 1988)
P—Ram P Bhala, MD
2900 West Oklahoma Avenue
Milwaukee, WI 53215

PE—Donna D Davidoff, MD
N10132 W23 Gettysburg
Mequon, WI 53092

ST—Sridhar V Vasudevan, MD
500 West Chambers Avenue
Milwaukee, WI 53210

On page 174 under the Officers of Specialty Sections of the State Medical Society, the following change has been made:

Pathology

(November 1989)
C—David J Rothwell, MD
2025 East Newport Avenue
Milwaukee, WI 53211■

State Medical Society of Wisconsin

Final Report

Task Force on Rural Health

Approved by the Board of Directors Jan 19, 1988 for presentation to the House of Delegates at the Annual Meeting April 28–30 in Milwaukee

Upon accepting the presidency of the State Medical Society in March 1987, Kenneth M Viste Jr, MD, spoke to the House of Delegates, recommending the creation of an ad hoc committee to study the problems facing the delivery of rural health care in Wisconsin.

At the June 6, 1987 Board of Directors meeting, approval was given to create this Task Force on Rural Health, comprised of physicians and nonphysician members to look specifically at access to rural health care and its various ramifications, to gain additional physician input into its deliberations, and to report back to the Board of Directors and the 1988 House of Delegates.

Appointed to the Task Force on Rural Health were Doctor Viste as its chairman; John Beasley, MD, Madison; Timothy Devitt, MD, Soldiers Grove; James Esswein, MD, Cameron; Glen Heinzl, MD, Oconto; Marvin Parker, MD, Racine; William Raduege, MD, Woodruff; Marwood Wegner, MD, St Croix Falls; Greg Nycz of the Marshfield Medical Foundation, Marshfield; Tim Size of the Rural Wisconsin Hospital Cooperative, Sauk City; John Hartz, representative for the Wisconsin Hospital Association, Hudson; Judith Fryback of the Wisconsin Department of Health and Social Services, Madison; and Rinaldo Bonacci of the Coalition on Wisconsin Aging Groups, Ashland.

Serving on the Task Force in an ex-officio capacity was Fredric Moskol, director of the Office on Rural Health and the Department of Professional and Community Development at the University of Wisconsin, Madison. Also attending meetings was State Representative David Deininger, Monroe.

The Task Force on Rural Health held its first meeting on Aug 21, 1987 to hear member concerns, set priorities, and provide direction for the mailing of a rural physician survey. The Task Force met again on Oct 23, 1987, Dec 18, 1987, and Jan 15, 1988, and concluded its work with this final report and recommendations.

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I. Introduction

II. Summary of the Task Force recommendations

III. Analysis of rural physician survey

IV. Physician manpower concerns and recommendations

V. Hospital and physician payment differentials and recommendations

VI. Health care delivery as a rural development strategy and recommendations

VII. Addendum

State Medical Society of Wisconsin

Final Report
Task Force on Rural Health

Kenneth M Viste Jr, MD, *President*

I. Introduction

Efforts by the National Rural Health Association, the National Association of Community Health Centers, the W.K. Kellogg Foundation, the American Medical Association, state medical societies, and many other organizations have helped to focus needed attention to rural health care concerns.

More recently, numerous Congressional members joined together to form a Rural Health Care Coalition. Co-chaired by Oklahoma Democrat Mike Synar and Iowa Republican Tom Tauke, Coalition members and their allies in both houses of Congress have been pushing various proposals aimed at helping rural providers and strengthening rural health care delivery systems.

This growing rural health movement also helped to convince the U.S. Department of Health and Human Services to establish a federal Office of Rural Health as part of the Public Health Service. One of its roles will be to work with states, private foundations and professional associations in fashioning solutions to rural health care delivery problems. If anything, these actions demonstrate that government leaders will listen if people speak loudly enough.

The State Medical Society's Task Force on Rural Health, which I have been proud to chair, has also taken its charge seriously. Rural physicians were well represented by family physicians from all four corners of our state. The inclusion of non-physician members on the Task Force with expertise and interest in rural health care issues added to our effort.

Special recognition should also go to those Wisconsin rural physicians who responded to the Task Force survey. They helped by telling us their concerns which in turn helped us to prioritize our work given the limited number of meetings, and raised our consciousness in terms of the issues and status of rural health care in Wisconsin.

I have sensed from the physician survey results a certain degree of frustration with the payment inequities, regulatory burdens and competitive pressures among rural physicians much more so than what I found previously. A declining agricultural economy, an aging rural population, and greater numbers of unemployed and underemployed in rural Wisconsin have resulted in larger percentages of Medicare and Medicaid patients for rural hospitals, physicians and other providers. This reliance on government health care reimbursement, combined with payment inequities inherent therein, have placed rural health care providers at a severe competitive disadvantage with their urban counterparts. If ways are not found to assist rural providers, patients will eventually be the ones most harmed as access to services declines.

While the Task Force on Rural Health recognizes the need to reduce or eliminate these provider payment inequities, the members also agree that long-term solutions to rural health care concerns must be viewed in a broader perspective in relation to rural development strategies.

The survival of rural hospitals will depend upon community support and the strengths of the local economy, just as these rural economies are dependent on the continued presence of the community hospital. Oftentimes, the small community hospital is the largest employer in the area. It is the heart of the local health care delivery system, and a major plus for attracting and recruiting new physicians. At the same time, the local hospital is also a salient selling point in efforts to locate other business and industry to the area. Business, industry, medicine and government all need to be reminded of this important interrelationship.

The Task Force on Rural Health also recognizes the diversity of rural communities in Wisconsin, and the need for individualized responses to specific local health care concerns. Some rural hospitals will close in the future despite our best efforts to keep them financially stable. Will there still be uses for these facilities beyond their earlier role of providing acute care? Community support and involvement will be vital for determining the role of the local hospital in these rural health care delivery system alternatives.

Some of the recommendations will require referral to SMS Commissions/Committees; others may require introduction of legislation while still others will serve as the topic for ongoing discussions with the administration of both medical schools, the Wisconsin Congressional Delegation and other involved parties.

Finally, it is our hope as members of the Task Force on Rural Health that the Board of Directors will act accordingly to maintain an ongoing rural health discussion and commitment within the State Medical Society. Those of us who served on the Task Force agree that some continuity is needed—both to monitor the progress of our recommendations and to continue to address in more detail the challenges, problems and concerns confronting rural health care in Wisconsin. We would advise that the Secretary-General Manager of SMS report to the Board of Directors in one year on the progress toward these recommendations.

II. Summary of the Task Force Recommendations

The State Medical Society of Wisconsin's (SMS) Task Force on Rural Health submits the following recommendations with the hope of improving the delivery of medical care to rural Wisconsin:

Physician manpower

1. Encourage the medical schools to stress the importance of the primary care disciplines as quality career choices.

2. Encourage medical schools to develop/provide a primary care curriculum so that students will be provided with the academic foundation necessary to develop the skills that are essential to practicing quality medical care in a rural area.

3. Encourage the development of voluntary programs that promote the interaction between rural primary care physicians and students.

4. Encourage that all medical students at both medical schools have formal coursework in family medicine.

5. That as part of the residency selection criteria, an individual's likelihood to practice primary care in a rural setting be added as a positive selection criterium.

6. Maintain an adequate level of state funding for family practice residency programs.

7. Recognize/publicize that Wisconsin citizens benefit from GME programs, and that in order for GME programs to be successful, their support must be broad based—SMS should encourage/improve local support for family practice residency programs in rural areas.

8. Continue to oppose attempts at the federal level to reduce payments to hospitals for GME costs.

9. Continued support and expansion of the National Health Service Corps (NHSC) programs ensure a continued supply of health care professionals for rural health manpower shortage areas (HMSAs).

10. Originally proposed in 1980, the potential for the establishment of a State Health Service Corps utilizing state GPR dollars for its funding should be investigated. The idea of a state loan forgiveness program should also be researched.

11. Establishment of an Area Health Education Center (AHEC) should be pursued.

12. Efforts should be made to increase the number of applicants and admissions to the Medical College of Wisconsin and the University of Wisconsin from medically underserved areas.

13. Endorse and support New Physicians for Wisconsin, a physician placement service operated by the University of Wisconsin's Department of Professional and Community Development, and the Department of Family Medicine and Practice.

14. Support and participate in activities planned by the U.S. Public Health Service (PHS), the DHSS-DOH, and the WPHCA that enhance the provision of primary care services to medically underserved areas in Wisconsin.

15. Support and participate in the Wisconsin Health Service Delivery Coalition.

16. Improve the public image of the rural primary care physician by waging an aggressive campaign aimed at publicizing the quality of health care provided in rural areas.

17. Encourage physicians to become active in the community and encourage the community to get to know their physicians.

18. Continue SMS activities aimed at seeking modifications in state and federal legislation to create a more positive environment for practice.

19. Develop a rural health support system to provide physicians in isolated areas with opportunities for continuing medical education, management assistance for office records and billing systems, physician coverage of their offices for vacation, insurance coverage and other benefits. SMS should also consider sponsorship of the AMA-run Project USA which provides short-term replacement for NHSC and Indian Health Services physicians seeking time off for continuing education or vacations.

Hospital and physician payment differentials

1. SMS should aggressively seek an equitable and realistic reimbursement level for rural health care providers.

2. SMS should support the AMA-adopted recommendations that speak to the problem of urban/rural payment differentials under Medicare.

3. SMS should plan and pursue a political strategy designed to educate the Wisconsin Congressional Delegation to the problems of Medicare reimbursement inequities.

4. SMS should seek revisions to Medicare reimbursement methodologies so that physician housecalls are economically feasible.

5. SMS should seek revisions in the Medicare claims processing system that would speed reimbursement for services.

6. SMS should consider a public information campaign to alert policy-makers and the public to the problems experienced by rural health care providers and their patients.

7. SMS should further develop its ties to other organizations, such as WHA, Coalition of Wisconsin Aging Groups (CWAG) and others represented on the Task Force, to alleviate the problems of payment inequities.

8. SMS should support and contribute $500 to the Rural Hospital Equity Fund. SMS should also encourage its membership to request participation and contributions from their hospital boards as well.

Health care delivery as a rural development strategy

1. SMS should urge WHA and the Rural Wisconsin Hospital Cooperative (RWHC) support and cosponsorship for a Legislative Council study of the role of the Wisconsin Health and Educational Facilities Authority (WHEFA) and other op-

tions to strengthen capital financing assistance for economically distressed health care facilities in underserved areas.

2. SMS should urge introduction of legislation, providing state funding of planning grants for pilot projects in chronically underserved rural areas for the purpose of creating cooperative service programs and rural health care provider networks that would offer comprehensive primary care services.

3. SMS should urge WHA and the RWHC support and cosponsorship of a symposium on the future role of the small community hospital and community-based solutions to rural health care delivery systems.

4. SMS should jointly work with WHA and RWHC to formalize linkages between rural physicians and small hospital administrators through regional meetings and/or seminars to foster better physician/hospital administration relationships.

5. Under the premise that a viable rural health delivery system is a prerequisite to rural economic development, SMS should support the provision of state level services, geared toward assisting communities to incorporate rural health care system development into local economic development planning and needs assessment; acting as a clearinghouse for innovative community based solutions to preserving rural health care resources; and fostering improved, coordinated responses by state agencies for resolving rural economic development concerns.

III. Analysis of rural physician survey

To solicit input into its deliberations from other rural physicians, the Task Force on Rural Health sent a survey to SMS members and non-members in the smaller communities of counties with a population density of less than 200 persons per square mile.

Using the above methodology, the Task Force narrowed the mailing to 1,334 physicians in Wisconsin whose practices can be appropriately termed as predominantly rural. Physicians whose principal place of practice was located in Dane, Milwaukee, Brown, Kenosha, Racine, Waukesha, Washington, Ozaukee, Winnebago and Outagamie Counties were excluded from the survey mailing. In the remaining counties, efforts were made to limit the survey to those with business offices in town, villages and fourth class cities (with populations less than 10,000).

As follow-up to the initial mailing, the Wisconsin Hospital Association agreed to send a letter to small hospital administrators (facilities under 100 beds), urging physicians with practice privileges at these hospitals to respond to the Task Force survey.

Of the 1,334 questionnaires originally mailed, a total of 423 responses were returned and tabulated for an overall response of 32%. See addendum for numbered results of the survey, as well as a county-by-county distribution of the responses.

Except for the first survey question which was hand tabulated and categorized, the remainder of the survey was computer tabulated by Philip E. Klein, Custom Computer Graphics, McFarland, WI.

Although the results of the physician survey were also tabulated by state designated health service areas, age and type of practice (solo or group), no significant differences in responses could be found in relation to these variables.

A. Summary of Respondents

Physicians, 40 years of age or less, comprised 44% of the respondents to the survey. The majority of the physicians polled were general or family physicians (62%), followed by obstetrician-gynecologists (10%), and most respondents (56%) have been practicing in their current setting for ten years or less.

Of the physicians who responded, 74% practice in a group setting and the remainder in solo practice, representing a change from five years ago for 16% of the physicians. Small group settings (2-5 physicians) was the most frequent response (39%) in terms of rural physician practice arrangements, followed by group practices of 6-10 physicians (27%) and solo practice (27%).

More than 81% of the respondents to the survey noted affiliation with a prepaid health plan. Of these physicians, 74% attributed less than one-fourth of their patient caseload to participation in an HMO or PPO, while 22% noted HMO patient volumes in the range of 25-50%. Only 16% of the physicians surveyed planned to reduce their participation or association with prepaid health plans.

B. Future physician concerns

The rural physician survey began with an open-ended question, asking doctors to list the three most important issues that will face rural physicians during the next five years (see addendum for more detailed analysis). A total of 1,046 individualized responses were tabulated and categorized.

Physician reimbursements and regulations governing third party payments topped the list of concerns, nearly doubling the next commonly cited concern of medical liability. Specific responses referred to Medicare and Medicaid payments, the inequity of payment for rural vs. urban physicians and primary care vs. specialties, as well as general concerns regarding fixed fees and rising overhead. Other responses included restricted admission policies dictated by third party payers and other regulatory intrusions into patient care, the financial binds faced by small town HMO providers, growing write-offs and discounted care, the complexities of physician office management and peer review procedures.

Hospital concerns ranked third down the list of most frequently cited responses by physicians, and included remarks relating to inequities in DRG payments for rural vs. urban facilities, reduced occupancy, and the basic survival of small rural hospitals.

Rural physicians focused on family practice and primary care needs, and the recruitment and retention of physicians generally. Future specialty needs included obstetrics, orthopedics and emergency medical services. A number of responses expressed concerns regarding cross coverage and back-up support, the lack of personal time and continuing medical education opportunities, the cost of medical care, public perceptions of rural health care, the lack of adequate public transportation systems, the AIDS epidemic, access to "state of the art" diagnostic and support services, nurse shortages, a declining rural economy, and so on.

C. Issues needing SMS emphasis

The Task Force on Rural Health asked physicians what public policy issues require more emphasis by the SMS as a way of highlighting rural health care concerns.

A total of 74% of the respondents noted medical liability insurance among their picks to this multiple-response question. The response with the second highest frequency was "geographical variations in physician reimbursements under Medicare" at 67%, followed by hospital DRG reimbursements (55%), Medicaid and general relief payments and regulations (45%), health care affordability (42%), prepaid health care plan issues (41%), insurance for the uninsured (37%), and peer review (22%).

D. Affordability

The Task Force posed a number of questions in the survey with the intent of identifying health care access problems resulting from affordability concerns of patients.

A total of 27% of the respondents perceived serious problems now in access to health care due to an inability to pay, with 13% of the physicians undecided. Consistent with this survey finding, 27% of the respondents have seen a decline in patient utilization of family preventive care, while 34% of the physicians surveyed saw an increase in patients delaying needed treatment for health care problems.

While the majority of physicians responding do not see affordability of care as a major problem, a significant minority reported current problems in this area. When viewed in relation to other responses, the Task Force agreed that this finding provides cause for concern.

For example, 43% of the respondents have seen an increase in patients lacking basic health insurance coverage, compared to 38% who did not. In addition, 73% of the physicians surveyed said they have seen a growth in the number of patients relying on government-subsidized health care coverage during the past five years. More than 250 respondents, or 62%, have also seen a marked increase in the amount of write-offs for uncompensated care during this time, listing Medicare, Medicaid and charity care/uncollectibles as the primary reason for the increase, in that order. These findings were consistent with the results from another question, asking if physicians had seen a change in their net pre-tax income from their practice during the past five years. More than 59% of the respondents indicated either no change or a decrease in their incomes.

Physicians who responded also expressed pessimism in the future in terms of reducing this growth in uncompensated care. Most survey respondents (64%), in fact, expect their write-offs to worsen during the next five years, while 32% were unsure or expected no change. Similarly, a large percentage of respondents (45%) expect their income to worsen during the next five years. About 32% of the physicians surveyed could not predict or expected little or no change.

E. Availability of services

In addition to affordability concerns, the Task Force also posed a series of questions to assess rural physician opinions on the availability of health care services.

Approximately 26% of the respondents perceived serious problems in access due to the limited availability of health care services. Also, 71% of the physicians surveyed expect availability of specialized care to improve during the next five years.

On the other hand, 59% of the physicians surveyed noted an increase in hours which they are spending with their practice during the past five years, compared to 20% who saw a decrease and 22% who indicated no change. Similarly, 48% of the respondents indicated that they were providing more care directly compared to five years ago, while 44% said they were referring more patients.

Another telling survey result is the large number of respondents noting plans to recruit more physicians (71%). Family practice was the most frequently cited need (55%), followed by obstetrics (12%).

In an effort to identify troublesome spots regarding access, the Task Force queried rural physicians on the availability of specific services in their area. Emergency and trauma care, obstetrics, long-term care and home health care all seemed readily available and accessible, based on the responses. This dropped off appreciably, however, for neonatal, mental health and referral services for special needs, such as burns and transplants. In these instances, 54% of the physicians identified neonatal services as being available with effort or difficult to access.

More than 43% of the respondents identified mental health services in a similar fashion, while 54% listed referral services for special needs as available with effort or difficult.

The Task Force also questioned rural physicians on changes in the number of inpatient transfers to facilities outside of their area. A total of 148 physicians, or 36%, noted in the survey a marked increase in the number of transfers to hospital facilities outside of their area during the past five years. Of these 148 respondents, 50% indicated the unavailability of specialized care as the chief reason for this increase. Other reasons listed included liability insurance coverage (27%), DRG reimbursements (12%), and other explanations (14%).

Similarly, the Task Force surveyed physicians on the financial strength of their local hospital. Most respondents (83%) believed their local hospital was financially stable. However, 17% indicated that their local hospital was facing closure, merger or may need to seek local tax support.

F. Conclusions

Based on the survey results, the Task Force concluded that rural physicians do not perceive themselves as being in the midst of a rural health care crisis. Yet there is reason for concern in terms of ensuring future access to services.

There is a major need for rural physicians, especially in family practice, as evidenced by the responses indicating plans to recruit more colleagues. Rural physicians currently are spending more time with their practices than before. Many are providing more care directly. At the same time, however, most rural physicians have seen a decrease or little change in their incomes during the past five years despite longer hours.

Physician responses to the survey also pointed to a declining rural economy as well as an aging rural population. A marked increase in the number of patients relying on Medicare and Medicaid was noted by nearly three-fourths of the physicians responding to the survey. A similar trend was noted in the percentage of write-offs for uncompensated care by rural physicians during the past five years.

These findings do not paint a bright economic picture for new physicians contemplating a rural practice, and could in fact seriously hamper local recruitment efforts unless further attention is paid to the problem.

IV. Physician manpower concerns and recommendations

Access to health care in rural areas is difficult, in part, because of an inadequate number of physicians. While numerous studies have predicted an oversupply of physicians, the size and effect of the surplus still remains an important policy debate. The most renown supply study, the Graduate Medical Education National Advisory Committee (GMENAC) Report, predicted a surplus of 70,000 physicians by 1990 and 145,000 by 2000 (1). The Report further found that by 2000, the number of physicians will rise 72% versus a 19% increase in the general population. However, critics of GMENAC have concluded that shifting practice patterns, more women medical students, new medical school enrollment trends and a declining number of foreign graduates will result in a small surplus (2). Other supply experts have intimated that an overall increase in physician supply will correct the imbalances in geographic distribution over time. The theory became known as "diffusion (3,4)." Several follow-up studies have generally confirmed that while some diffusion is taking place, primary care physicians will still be greatly needed in shortage areas (5).

While the physician supply debate continues among policymakers, so does the need for providers in rural areas. National statistics indicate that rural areas with 30% of the U.S. population have only 12% of the physicians (6). In addition, most rural physicians when compared with the national average are nearing retirement and recruitment of "new" physicians to rural areas is difficult at best. Such factors as low population density, depressed rural economies, professional isolation and fewer continuing medical education opportunities, continue to act as disincentives for physicians who may have otherwise chosen to practice in a rural setting.

In rural Wisconsin, the need for primary care physicians remains clear. As reflected in the Task Force's physicians poll, 71% of the respondents indicated they or their groups are planning to recruit more physicians, primarily primary care physicians. In addition, New Physicians for Wisconsin, a physician placement service sponsored by the University of Wisconsin's Department of Professional and Community Development and the Department of Family Medicine and Practice, is actively recruiting family physicians in 75 Wisconsin communities. And finally, the National Health Service Corps (NHSC), a federal program where physicians are placed in federally-designated shortage areas and in return receive payment for the costs of their medical education, currently has 64 physicians placed in shortage areas around the state. NHSC health manpower shortage areas and the provider match are reviewed on an annual basis. Wisconsin has been approved to match eleven new providers by July, 1988. NHSC placements are designed to increase access to health care to citizens in remote and medically underserved areas of the state. NHSC providers also serve the uninsured by accepting patients who are unable to pay normal charges on a sliding scale fee basis. Task Force members agreed that the ***demand*** for physicians in rural Wisconsin clearly

exists and that efforts are best spent by creating incentives to attract primary care physicians to rural areas.

The Task Force recommendations listed below are designed to create incentives by assuring a strong primary care educational base, supporting current recruitment efforts, and improving the general environment for practice.

The recommendations are subdivided in three categories—medical education, recruitment, and practice environment.

A. Medical Education

At the heart of the supply issue is the need to assure that undergraduate and graduate medical education programs in Wisconsin remain affordable and available. As primary care physicians are the mainstay of rural physician manpower, our focus here should assure a strong primary care educational base. Recommendations associated with medical education follow.

Undergraduate medical education

The foundation for medical practice begins with undergraduate medical education—primary care being an increasingly important legitimate component of that education.

To strengthen the role of primary care in undergraduate medical education, the Task Force recommends that SMS:

1. ***Encourage the medical schools to stress the importance of the primary care disciplines as quality career choices.*** Problems in maldistribution will persist until the medical profession consistently recognizes the importance of primary care. Medical schools should play a greater role in fostering the primary care disciplines as legitimate/quality career choices. Formal primary care training should be available before the fourth year of a student's education.

2. ***Encourage medical schools to develop/provide a primary care curriculum so that students will be provided with the academic foundation necessary to develop the skills that are essential to practicing quality medical care in a rural area.*** Programs and curriculum should be developed by the medical schools to assure that medical students have the necessary training and skills to pursue a rural primary care practice.

3. ***Encourage the development of voluntary programs that promote the interaction between rural primary care physicians and students.*** Currently there are few programs that give students an opportunity to experience the practice of medicine in a rural primary care setting. The Academy of Family Physicians operates a Summer Externship Program which should be expanded while others are developed.

4. ***Encourage that all medical students at both medical schools have formal coursework in family medicine.*** Since most rural primary care physicians are family physicians an equal educational emphasis in this specialty compared with the other primary care parent specialties (internal medicine, pediatrics) should be achieved.

Graduate medical education (GME)

Training opportunities for primary care physicians should also be available in sufficient supply. While the Task Force did not attempt to define what the appropriate mix of residencies in primary care and subspecialty care should be, additional SMS activities in this area may attempt to address such a definition. In order to assure adequate residency training slots in primary care, SMS recommends:

5. ***That as part of the residency selection criteria, an individual's likelihood to practice primary care in a rural setting be added as a positive selection criterium.***

6. ***Maintain an adequate level of state funding for family practice residency programs.*** As family practice and other primary care training programs are usually financially vulnerable because of their limited ability to generate fees, the Task Force is particularly concerned that these residency programs remain viable. Additional state funding for other primary care training opportunities should be sought to assure a solid primary care training base.

7. ***Recognize/publicize that Wisconsin citizens benefit from GME programs, and that in order for GME programs to be successful, their support must be broad based—SMS should encourage/improve local support for family practice residency programs in rural areas.*** Local support should include financial support, hospital support and medical staff support.

8. ***Continue to oppose attempts at the federal level to reduce payments to hospitals for GME costs.*** The vulnerability of GME support is great as threats by Congress to reduce Medicare payments to hospitals for the direct and indirect costs of GME continue.

Cost of medical education

High tuition costs are clearly a disincentive to pursuing a medical education. In the long run, this will only aggravate the physician supply problem. As a result, tuition should be kept as low as possible, and federal and state programs aimed at reducing this financial burden should be explored and supported. Task Force members recommend:

9. *Continued support and expansion of the National Health Service Corps (NHSC) programs ensure a continued supply of health care professionals for rural health manpower shortage areas (HMSAs).* SMS should continue to work with the Wisconsin Academy of Family Physicians, DHSS Division of Health (DOH), the Wisconsin Primary Health Care Association (WPHCA) and other organizations interested in assuring the continued availability of NHSC positions.

10. *Originally proposed in 1980, the potential for the establishment of a State Health Service Corps utilizing state GPR dollars for its funding should be investigated.* The idea of a state loan forgiveness program should also be researched. SMS efforts to research the idea of a state supported loan forgiveness program should be coordinated with the DHSS-DOH and the WPHCA. DOH staffed the Council on Medical Education Loan Repayments Grants in 1981-82. All of the original working papers remain on file and DOH staff have renewed efforts to develop a new proposal.

11. *Establishment of an Area Health Education Center (AHEC) should be pursued.* AHEC programs are cooperative programs involving not only the AHEC itself, but one or more medical schools. AHECs are designed to improve the distribution, supply, quality, utilization and efficiency of health personnel in the health services delivery system and to encourage the regionalization of education responsibilities of health professions schools. Wisconsin has already in place a number of resources (particularly the University of Wisconsin family practice program) to make the program successful. Public Health Service monies are available to assist in the planning, development and operation of the AHEC program.

Admissions

There is some concern that students from medically underserved areas in primary and secondary schools are not sufficiently encouraged to consider medicine as a career. As a result, the Task Force recommends that:

12. *Efforts should be made to increase the number of applicants and admissions to the Medical College of Wisconsin and the University of Wisconsin from medically underserved areas.* As an example, programs aimed at promoting health careers in schools should be encouraged. Physicians and other local health care providers should be encouraged to attend these events to discuss their careers with students.

B. Recruitment

Supporting direct recruitment efforts are important as the results for the community are often more immediate. Task Force members recommend that SMS:

13. *Endorse and support New Physicians for Wisconsin, a physician placement service operated by the University of Wisconsin's Department of Professional and Community Development, and the Department of Family Medicine and Practice.*

14. *Support and participate in activities planned by the U.S. Public Health Service (PHS), the DHSS-DOH, and the WPHCA that enhance the provision of primary care services to medically underserved areas in Wisconsin.* The DHSS-DOH has been awarded a grant from the U.S. PHS to implement a "Cooperative Agreement." The agreement allows the DOH along with the WPHCA to coordinate efforts that support the expansion of community-based primary care and preventive services. The workplan also calls for coordinating efforts in the areas of 1) recruitment and retention of primary health care physicians, 2) developing a state supported loan forgiveness program, and 3) assessing the feasibility of a "locum tenens" program for rural primary care physicians in the state.

15. *Support and participate in the Wisconsin Health Service Delivery Coalition.* The WPHCA recently received a $5,000 grant from the Public Health Service (PHS) to establish the Coalition in an effort to plan short-term and long-term strategies for improving health care delivery to underserved areas of the state. Special attention will be devoted to Wisconsin's ability to recruit and retain an adequate supply of physicians. The Coalition will be comprised of state and national health care organizations. Examples of potential Coalition members include U.S. Public Health Service, Department of Health and Social Services, University of Wisconsin Office of Rural Health, National Rural Health Association, Wisconsin Hospital Association, Medical College of Wisconsin, University of Wisconsin Department of Family Medicine and Practice, Wisconsin Academy of Physicians, Wisconsin Institute for Family Medicine, American Medical Association—medical student representative.

C. Practice environment

Efforts should continue to make the practice of medicine an attractive career. This effort includes a multi-faceted approach that involves not only improving the public image of physicians, but also continuing to seek legislative relief from those regulations that create disincentives to practicing medicine. Task Force members recommend that SMS:

16. *Improve the public image of the rural primary care physician by waging an aggressive campaign aimed at publicizing the quality of health care provided in rural areas.* This campaign should be a joint effort with the Wisconsin Academy of Family Physicians and any other interested organizations.

17. *Encourage physicians to become active in the community and encourage the community to get to know their physicians.* Physicians and other health care providers should be serving as role models for youth. Physicians and business leaders should also be encouraged to get to know each other. For example, physicians could join the local Chamber of Commerce.

18. *Continue SMS activities aimed at seeking modifications in state and federal legislation to create a more positive environment for practice. Examples of these activities include:*

—Eliminating DRG discrepancies between urban and rural providers,

—Supporting current Tort Reform efforts, and

—Supporting changes in Medicare Part B payments that provide incentive payments for primary care physicians in underserved areas.

19. *Develop a rural health support system to provide physicians in isolated areas with opportunities for continuing medical education, management assistance for office records and billing systems, physician coverage of their offices for vacation, insurance coverage and other benefits. SMS should also consider sponsorship of the AMA-run Project USA which provides short-term replacement for NHSC and Indian Health Services physicians seeking time off for continuing education or vacations.*

V. Hospital and physician payment differentials and recommendations

Federal policy has sent mixed messages to rural providers. For example, federal programs, such as the NHSC, have encouraged physicians to practice in rural areas. On the other hand, Medicare has adopted a reimbursement methodology that clearly acts as a disincentive to rural practice.

While many projections on payment inequities exist, Task Force members undertook an independent review of the data. A subgroup consisting of Tim Size of the Rural Wisconsin Hospital Cooperative, Greg Nycz of the Marshfield Medical Foundation and SMS staff was formed to look at this issue in more detail. The subgroup findings were then reported to the full Task Force.

Since Medicare data is readily available and most rural hospital patients are Medicare recipients, the Task Force members reviewed Medicare data to detect payment patterns. This data was provided by the Health Care Financing Administration (HCFA) and Wisconsin Physicians Service.

In reviewing urban and rural hospital reimbursement under the Prospective Payment System (PPS), differences ranging from 9-60% were found. Additional information was provided by Tim Size as part of his research for the National Rural Health Association (NRHA). In a recent report on Medicare reform, Mr. Size defines the urban/rural differential by adjusting for area wages and then combining an adjustment for wages and case mix. These definitions result in a differential of either 17%, 40%, or 60% depending on the type of adjustment assumed (see addendum). Using this information, urban hospitals on the average, are paid 40% more than rural hospitals for the same service. To further demonstrate this point, the Texas Hospital Association indicated that for patients with diagnosis related group (DRG) 89 (Pneumonia) an urban hospital is reimbursed $5,300 but a rural hospital receives only $2,200 for patients in this same DRG. In Wisconsin, rural hospitals will be paid $2,629 for treating a patient with pneumonia, while a Madison hospital gets $3,668.

Underlying these discrepancies are HCFA assumptions that labor costs and case-mix severity are greater in urban areas. However, these assumptions have yet to be documented by HCFA. While these issues continue to be studied, solutions do not appear in sight in the near future. One exception is that the NRHA has initiated a constitutional challenge to HCFA's inequitable administration of PPS. Funds to finance the suit are being raised and a legal brief is expected to be filed in late spring.

While urban/rural hospital differentials under PPS have been well publicized, little attention has been given to the plight of the rural physician. With the research assistance of the SMS Division of Medical Policy and Practice, the Task Force reviewed Medicare adjusted prevailing charges for the ten most common procedures for family physicians in all eleven Wisconsin localities. While the data along with a map of Wisconsin localities is included in the addendum, a few observations deserve mention. Depending on which localities are compared, the differences in reimbursement vary from 0 to 48%. Not surprisingly, the most marked differential is between providers in Milwaukee compared to those in northwest Wisconsin. Adjusted prevailing charges in the northwest and southwest areas of the state appear the lowest of all locality prevailings statewide.

In general, family physicians in urbanized localities have higher adjusted prevailing charges and as a result are often reimbursed at a higher rate than rural family physicians. Physicians who responded to the Task Force's poll reported that geographic variations in physician reimbursement is one of their chief concerns second only to concerns about medical liability. These differences combined with the fact that Medicare sets limits on what a physician can charge create a dismal picture for the rural physician treating Medicare patients.

As with hospitals, it is also assumed that practice overhead costs for rural physicians are lower than for urban physicians. While this premise has not yet been proven, it is speculated that almost two in five family

physicians have annual professional expenses of $100,000 or more, as compared to about one in four of their primary care colleagues (7). In addition, rural physicians report that their labor costs are equal to those in the urban market since they are competing with urban offices for trained personnel.

Task Force members were also concerned about payment issues from the consumer's perspective. Only recently did Minnesota HMOs announce that as of January 1, 1988, patients from twenty-eight rural counties (totaling 26,000 beneficiaries) would be dropped from coverage because of the low reimbursement rates from the federal government. Out-of-pocket expenses are also increasing for the elderly—a population that tends to have limited finances primarily due to fixed incomes. A 1987 federal study reported that yearly out-of-pocket expenses for Medicare Part B (physician) services average $516 per person up from $395 in 1980. Most of this increase is attributed to the rise in federally-required copayments and deductibles.

Demographic statistics reviewed by the Task Force illustrated additional consumer trends. As an example, counties with a lower population per square mile also have a higher percentage of the elderly and lower median family incomes. This information is further detailed in the addendum. Since rural workers are either self-employed, employed by a small company or seasonally employed, rural populations also tend to be uninsured or underinsured. Thus, while the need for health care in rural areas is great, often the ability of rural residents to pay for their health care is limited.

Federal payment policies are negatively affecting consumers, physicians, and hospitals. Payment inequities for physicians create great disincentives for establishing rural practices. This scenario makes it difficult for communities to recruit and retain physicians. The economic strength of rural hospitals is also threatened by the loss of federal dollars under PPS. When hospitals and physicians lose, not only is access to health care compromised, but the entire community loses as well. For these reasons the Task Force recommends that:

1. ***SMS should aggressively seek an equitable and realistic reimbursement level for rural health care providers.*** Third party payors and particularly Medicare should not discriminate against physicians or patients based on practice location or place of residence. In addition to reviewing Medicare data on physician charges the Task Force also reviewed data on patient costs under Medicare risk contracting. The data showed that while Medicare Part B premium payments for all patients are the same (25% of program costs):
1) the amount of out-of-pocket costs may vary considerably as a result of where patients receive the service; and 2) the return (in terms of dollars spent on medical care) is much lower for beneficiaries residing in rural areas, resulting in unfair transfer payments out of small communities (8).

2. ***SMS should support the AMA-adopted recommendations that speak to the problem of urban/rural payment differentials under Medicare. The AMA recommendations include:***
—eliminating prospective pricing system provisions that result in inequitable differences in reimbursement levels to rural hospitals, and ensuring that any differences in such DRG payments are based on true differences in the cost of providing services by such hospitals;
—replacing Medicare's current CPR-based method of physician payment with an indemnity fee schedule, derived from a resource-based relative value scale, which would eliminate inappropriate and unjustified reimbursement differences between rural and urban areas; and
—pending such structural payment reform, eliminating the Medicare Economic Index as the major impediment to allowing rural physicians' reimbursement to rise to reflect true costs of providing care (Council on Medical Service, Report K, I-87).

3. ***SMS should plan and pursue a political strategy designed to educate the Wisconsin Congressional Delegation to the problems of Medicare reimbursement inequities.*** SMS should advocate the following:
(a) Comprehensive and equitable revision of the method by which providers are reimbursed under the Medicare program (as outlined above);
(b) Support our Delegation's membership to the Senate Rural Health Caucus and Rural Health Care Coalition. The Coalition currently is advocating five bills aimed at seeking relief for rural providers, many of which have already been included in Budget discussions; and
(c) Pending comprehensive payment reform in the Medicare program, SMS should support federal initiatives aimed at easing the burden of rural providers. Examples of these initiatives have been discussed as part of the Budget deliberations:

—Hospital Payments: Hospitals in rural areas would receive an additional one percent increase for fiscal year 1988-fiscal year 1990.
—Swing Beds: The bill would amend the special procedures for payment to rural hospitals used to provide extended care services to allow hospitals with fewer than 100 beds, rather than 50, to qualify.
—Sole Community Hospitals: Sole community hospitals are eligible for special payment when there is a decrease of more than five percent in the number of their inpatient cases due to circumstances beyond their control.

—Rural Referral Centers: Rural with 275 beds, rather than 500, could qualify as rural referral centers.

—Incentive Payments for Rural Primary Care Physicians: In the case of services provided by a primary care physician to an individual who is covered under Medicare in rural areas with a physician population ratio of 1 to 4,500 or worse, there would be paid to the physician, in addition to amounts otherwise authorized under Medicare, an amount equal to 10 percent of the prevailing charge for the service in the locality in which the service is performed. This bill defines the term primary care physician to mean a physician whose primary practice of medicine is in the field of family practice, general practice, general internal medicine, gynecology, or pediatrics.

—Rural Health Clinic Maximum Rates: This bill would increase from the current $32.10 per visit to $46 a visit in 1988 the payment made for rural health clinic services provided by independent rural health clinics.

4. *SMS should seek revisions to Medicare reimbursement methodologies so that physician house-calls are economically feasible.* Methodologies should also allow compensation for time and mileage.

5. *SMS should seek revisions in the Medicare claims processing system that would speed reimbursement for services. This is particularly an important issue for physicians practicing in small groups and rural areas.*

6. *SMS should consider a public information campaign to alert policy-makers and the public to the problems experienced by rural health care providers and their patients.*

7. *SMS should further develop its ties to other organizations, such as WHA, Coalition of Wisconsin Aging Groups (CWAG) and others represented on the Task Force, to alleviate the problems of payment inequities.* Coordinated efforts should seek changes in federal policy in all levels—administrative, congressional and judicial. As an example, the WHA's Board of Trustees has adopted a position that endorses a one rate system with adjustments only for severity of illness and for wages paid to non-professional employees. WHA, like SMS, has also met with the Wisconsin Congressional Delegation on payment equity issues. A coordinated strategy between WHA, SMS and others may prove to emphasize the importance of these issues to our Delegation.

8. *SMS should support and contribute $500 to the Rural Hospital Equity Fund. SMS should also encourage its membership to request participation and contributions from their hospital boards as well.* The NRHA has initiated a constitutional challenge to HCFA's administration of the Prospective Payment System. Funds are being raised to finance the suit.

VI. Health care delivery as a rural development strategy and recommendations

As an industry, Wisconsin's 139 non-federal general medical-surgical hospitals contribute more than $2.4 billion to the state economy. Hospitals with fewer than 50 beds, and facilities with capacities between 50 and 100 beds, contribute heavily to this economic picture.

According to State Division of Health statistics, hospitals with fewer than 50 beds—most of which are rural—have a total payroll in excess of $53 million and combined expenses of nearly $115 million. Facilities within the 50 to 100-bed range contribute $168.5 million to the state's economy, $78.5 million of which is payroll-related.

Among the 139 non-federal acute care hospitals in Wisconsin, a total of 74 are classified as rural under Medicare designations. A breakdown of these facilities from the Wisconsin Hospital Association (WHA) follows:

Bed Size	Urban	Rural	Total
0-49	7	37	44
50-99	8	23	31
100-250	19	11	30
250+	31	3	34

In reviewing the financial status of rural hospitals in the state, the Task Force on Rural Health looked at a WHA analysis which showed several disturbing trends. The WHA analysis was based on 1985 audited financial statements for Wisconsin hospitals, Medicare cost reports, and State Division of Health data. The analysis confirmed that small rural hospitals treat higher percentages of Medicare patients. Substantial drops in net income and operating margin percentages were noted for hospitals with less than 50 beds, followed by facilities with capacities of 50-99 beds. Smaller facilities also realized lower returns on total assets and equity, compared to larger hospitals.

The Task Force also reviewed 1986 profit/loss data for general medical-surgical hospitals in the state. A total of 41 hospitals in Wisconsin reported net losses last year, 30 of which were classified as non-urban by the Wisconsin Department of Health and Social Services. The largest number of hospitals reporting losses in 1986 were in the 0-49 bed size, followed by facilities with capacities of 50-99 beds.

Consistent with rural physician survey responses, members of the Task Force on Rural Health agreed that the problems of rural hospitals represented one of the major rural health concerns in terms of potentially jeopardizing access to care. Task Force members also concurred that small community hospitals need to be increasingly viewed as a community and rural development resource.

Listed below are the Task Force recommendations for this section.

1. *SMS should urge WHA and Rural Wisconsin Hospital Cooperative (RWHC) support and cosponsorship for a Legislative Council study of the role of the Wisconsin Health and Educational Facilities Authority (WHEFA) and other options to strengthen capital financing assistance for economically distressed health care facilities in underserved areas.*

Formerly the Wisconsin Health Facilities Authority, WHEFA has been providing capital financing assistance to hospitals and nursing homes in the state since 1979, acting as a conduit for nearly $800 million in public and private bond issuances for new capital projects and refinancings since its start-up. Recent federal tax law changes, however, limit the ability of WHEFA to assist smaller capital financing projects, and increase borrowers' out-of-pocket costs associated with public bond issues.

Currently, the Legislative Audit Bureau is conducting a performance audit of WHEFA to determine whether the Authority could play a stronger role in assisting rural hospitals and smaller health care facilities. A broader legislative study could expand from this audit to determine what additional state initiatives might be in order to assist rural hospitals.

2. *SMS should urge introduction of legislation, providing state funding of planning grants for pilot projects in chronically underserved rural areas for the purpose of creating cooperative service programs and rural health care provider networks that would offer comprehensive primary care services.*

During its deliberations, the Task Force on Rural Health reviewed several initiatives from other states that provide financing for rural health care networking arrangements and other rural health care delivery system alternatives. New York and North Carolina were two states highlighted for their financial assistance efforts aimed at improving primary care services to underserved populations. These programs offer a range of help from planning grants and capital financing to operational cost subsidies.

A state-level planning grant program in Wisconsin would provide a financial carrot and stronger incentives for communities, non-profit groups and other organizations to develop alternatives to traditional, urban-based health care delivery systems for underserved populations.

3. *SMS should urge WHA and the RWHC support and cosponsorship of a symposium on the future role of the small community hospital and community-based solutions to rural health care delivery systems.*

The Task Force on Rural Health briefly reviewed two multi-state rural health projects, currently underway and nearing completion, by the Center for Rural Health Services, Policy and Research at the University of North Dakota and by the University of Washington's Department of Family Medicine. Each project is funded by a W.K. Kellogg Foundation grant, and is aimed at preserving the small rural hospital as a community resource. Community-wide planning and local needs assessments are key elements in each project, and will hopefully give further direction on how best to achieve an integrated, community-based response to rural health care delivery problems.

A Wisconsin symposium on rural health could give physicians, hospital administrators, business leaders, educators and other community members an opportunity to view the results of these grant programs, provide leadership to communities at risk of losing their hospitals, as well as begin the groundwork for cooperative efforts within the community to preserve and enhance local health care delivery systems.

The proposed symposium should be expected to cover a broad range of rural health-related issues, and would help to inventory existing programs and funding sources as well as propose new initiatives to continue acute care to communities which lose their current hospital, and improve access to primary and specialized care services. The problem of rural transportation for the home-bound should also be addressed at this symposium. During the course of the meetings, Task Force members became very concerned that rural patients, particularly the elderly, suffer limited access to health care because of a variety of factors including the lack of public transportation, transportation in general and less adequate telephone service. While some larger clinics are attempting to coordinate appointments for patients from the same area so that transportation can be arranged, mobility is still limited for most. Community-based programs aimed at improving transportation can make a big difference for those who are isolated.

4. *SMS should jointly work with WHA and the RWHC to formalize linkages between rural physicians and small hospital administrators through regional meetings and/or seminars to foster better physician/hospital administration relationships.*

Task Force members agreed that open communication between hospital administrators and medical staff is vital to the survival of small rural hospitals. The Task Force also recognized that physician/administration relationships may vary dramatically from one facility and community to another, and strained relations will only exacerbate the problems faced by rural hospitals. Before serious discussion can begin locally on community-based solutions to rural health care delivery problems, strong working relationships between physicians and administrators must already be in place. Efforts by SMS, WHA, and RWHC to formalize linkages on a statewide or regional basis would help to develop better communication and understanding between these groups.

5. *Under the premise that a viable rural health delivery system is a prerequisite to rural economic development, SMS should support the provision of state-level services geared toward assisting communities to incorporate rural health care system development into local economic development planning and needs assessments; acting as a clearinghouse for innovative community-based solutions to preserving rural health care resources; and fostering improved, coordinated responses by state agencies for resolving rural economic development concerns.*

As one part of the equation, Governor Thompson has proposed in the 1988–89 annual state budget bill $50,000 GPR and one FTE position in the Department of Development to operate an information clearinghouse for state and federal rural development efforts, and to coordinate the state's response to rural economic development problems. By itself, however, this proposed DOD activity is unlikely to give top priority to rural health delivery systems as an economic development issue.

Additional changes that could be pursued by SMS include statutory recognition and increased funding for the UW Office on Rural Health to assist communities with planning and needs assessments, and well-defined mechanisms within state government for interdepartmental responses to rural health and economic development concerns.

VII. Addendum

1. Survey Results
2. HCFA Data on Hospital Differentials
3. Medicare Data on Adjusted Prevailing Charges for Wisconsin Family Physicians
4. Demographic Characteristics for Counties Grouped by Percentile Ranking of Federal Medicare Payments

Further information on the above four items is available upon request to Deborah Wilke of the SMS Division of Public Affairs: (608) 257-6781 or 1-800-362-9080.

Footnotes

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2. Jacobsen, Steven J., and Alfred A. Rimm, "The Projected Physician Surplus Reevaluated," *Health Affairs,* Summer 1987.
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The World's Most Popular K*

Slow-K®

potassium chloride
slow-release tablets
8 mEq (600 mg)

It means "dependability" in almost any language

*Based on worldwide sales data on file, CIBA Pharmaceutical Company.
Capsule or tablet slow-release potassium chloride preparations should be reserved for patients who cannot tolerate, refuse to take, or have compliance problems with liquid or effervescent potassium preparations because of reports of intestinal and gastric ulceration and bleeding with slow-release KCl preparations.

Before prescribing, please consult Brief Prescribing Information on next page.

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128-3568-A

The World's Most Popular K

For good reasons

- ☐ **It works**—a 12-year record of efficacy[1]
- ☐ **It's safe**—unsurpassed by any other KCl tablet or capsule[2]*
- ☐ **It's acceptable vs liquids**—greater palatability, fewer GI complaints, lower incidence of nausea[2]
- ☐ **It's comparable to 10 mEq**—in low-dosage supplementation[3]†
- ☐ **It's economical**—less expensive than all other leading KCl slow-release supplements on a per tablet cost to the patient[1]

Slow-K®
potassium chloride
slow-release tablets 8 mEq (600 mg)

For patients who can't or won't tolerate liquid KCl.

*The most common adverse reactions to potassium salts are gastrointestinal side effects.

†Pooled mean serum potassium following oral administration of 30 mEq K-Tab compared to 24 mEq Slow-K in diuretic-treated hypertensives (n = 20) over 8 weeks.

CIBA

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Slow-K®
potassium chloride USP
Slow-Release Tablets
8 mEq (600 mg)

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE INSERT)

INDICATIONS AND USAGE

BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure; hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy; and certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure; systemic acidosis such as diabetic acidosis; acute dehydration; extensive tissue breakdown as in severe burns; adrenal insufficiency; or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS

Hyperkalemia (See OVERDOSAGE)

In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics

Hyperkalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis

Hyperkalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS

General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients

Physicians should consider reminding the patient of the following:

To take each dose without crushing, chewing, or sucking the tablets.

To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.

To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.

To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests

Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions

Potassium-sparing diuretics: see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSAGE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

HOW SUPPLIED

Tablets—600 mg of potassium chloride (equivalent to 8 mEq) round, buff colored, sugar-coated (imprinted Slow-K)

Bottles of 100	NDC 0083-0165-30
Bottles of 1000	NDC 0083-0165-40
Consumer Pack—One Unit	
12 Bottles—100 tablets each	NDC 0083-0165-65
Accu-Pak® Unit Dose (Blister pack)	
Box of 100 (strips of 10)	NDC 0083-0165-32

Do not store above 86°F (30°C). Protect from moisture. Protect from light.

Dispense in tight, light-resistant container (USP).

Dist. by:
CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

C87-31 (Rev. 8/87)

CIBA

128-3568-A

Before prescribing, see complete prescribing information in SK&F LAB CO. literature or PDR. The following is a brief summary.

Contraindications: There are no known contraindications to the use of 'Tagamet'.

Precautions: While a weak antiandrogenic effect has been demonstrated in animals, 'Tagamet' has been shown to have no effect on spermatogenesis, sperm count, motility, morphology or in vitro fertilizing capacity in humans.

In a 24-month toxicity study in rats at dose levels approximately 9 to 56 times the recommended human dose, benign Leydig cell tumors were seen. These were common in both the treated and control groups, and the incidence became significantly higher only in the aged rats receiving 'Tagamet'.

Rare instances of cardiac arrhythmias and hypotension have been reported following the rapid administration of 'Tagamet' HCl (brand of cimetidine hydrochloride) injection by intravenous bolus.

Symptomatic response to 'Tagamet' therapy does not preclude the presence of a gastric malignancy. There have been rare reports of transient healing of gastric ulcers despite subsequently documented malignancy.

Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chlordiazepoxide, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.), demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. (Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.)

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

Adverse Reactions: Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states (e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation), predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving 'Tagamet', particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in 'Tagamet'-treated patients (approximately 1 per 100,000 patients), including agranulocytosis (approximately 3 per million patients), have been reported, including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia (approximately 3 per million patients) and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly unlikely. A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving 'Tagamet' has been reported.

How Supplied: Tablets: 200 mg. tablets in bottles of 100; 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only); 400 mg. tablets in bottles of 60 and Single Unit Packages of 100 (intended for institutional use only), and 800 mg. Tiltab® tablets in bottles of 30 and Single Unit Packages of 100 (intended for institutional use only).

Liquid: 300 mg./5 ml., in 8 fl. oz. (237 ml.) amber glass bottles and in single-dose units (300 mg./5 ml.), in packages of 10 (intended for institutional use only).

Injection:

Vials: 300 mg./2 ml. in single-dose vials, in packages of 10 and 30, and in 8 ml. multiple-dose vials, in packages of 10 and 25.

Prefilled Syringes: 300 mg./2 ml. in single-dose prefilled disposable syringes.

Plastic Containers: 300 mg. in 50 ml. of 0.9% Sodium Chloride in single-dose plastic containers, in packages of 4 units. No preservative has been added.

ADD-Vantage®* Vials: 300 mg./2 ml. in single-dose ADD-Vantage® Vials, in packages of 25.

Exposure of the premixed product to excessive heat should be avoided. It is recommended the product be stored at controlled room temperature. Brief exposure up to 40°C does not adversely affect the premixed product.

'Tagamet' HCl (brand of cimetidine hydrochloride) injection premixed in single-dose plastic containers is manufactured for SK&F Lab Co. by Travenol Laboratories, Inc., Deerfield, IL 60015.

* ADD-Vantage® is a trademark of Abbott Laboratories.

BRS-TG:L73B Date of issuance Apr. 1987

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Cidra, P.R. 00639
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In peptic ulcer:
RELIEF
REASSURANCE
REWARD

Tagamet®
brand of cimetidine
First to Heal

You'll both feel good about it.

RESULTS

Motrin® 800 mg TABLETS
ibuprofen

Extra strength
Convenience
Economy

Upjohn
A Century of Caring
1886·1986

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J-6138 January 1986

Medicare reduces payment for certain procedures

The following physician services to Medicare patients will have payment reductions, subject to specific "inherent reasonableness," beginning April 1, 1988:

Service	*CPT Code*
Bronchoscopy	(31622-31626)
Carpal tunnel neurolysis and/or transposition	(64721)
Cataract surgery	(66830-66985)
Coronary artery bypass surgery	(33510-33528)
Diagnostic and/or therapeutic dilation and curettage	(58120)
Knee arthroplasty	(27446-27447)
Knee arthroscopy	(29880-29881)
Pacemaker implantation surgery	(33206-33208)
Suprapubic prostatectomy	(55821)
Total hip replacement	(27130-27132)
Transurethral resection of the prostate	(52601)
Upper gastro-intestinal endoscopy	(43235-43239)

All prevailing charges for these services will be reduced by 2% for the nine-month period beginning April 1. There will be additional reductions of up to 15% for these services if the original prevailing charge exceeds 85% of a national average prevailing charge. HCFA will require a reduction of $\frac{3}{13}$ of a percentage point for each percentage point that the reduced prevailing charge exceeds the weighted national average charge. For example, if the prevailing charge (reduced by 2%) is 150% of the national charge, the prevailing charge would be reduced by another 15% ($\frac{3}{13} \times 65$ points). A 15% reduction is the maximum reduction that can be taken.

1988 MAACs for these services will be determined by a different calculation: Take 125% of the prevailing charge that was reduced by 2%, and add ½ of the difference between the 125% level and the 1987 MAAC. This is the 1988 MAAC.■

Medical Assistance copayments: update

The SMS received numerous calls from clinic managers and physicians across the state regarding the new Medical Assistance copayments. While the SMS generally supports the concept of copayments, the staff was very concerned about the process used to implement these copayments. Secretary-General Manager Thomas L Adams, in a letter to the State Division of Health, emphasized the lack of provider notification of these changes: "We strongly oppose your holding providers responsible for changes that they are not aware of and do not know how to implement . . . We, therefore, request that the implementation date of these changes be made effective March 1, 1988."

The Division of Health agreed to the SMS request, and the copayment program will be implemented for dates of service on or after March 1. The Bureau of Health Care Financing will notify providers of the new effective date when they mail the provider bulletin which explains the new copayments. These new copayments will be:

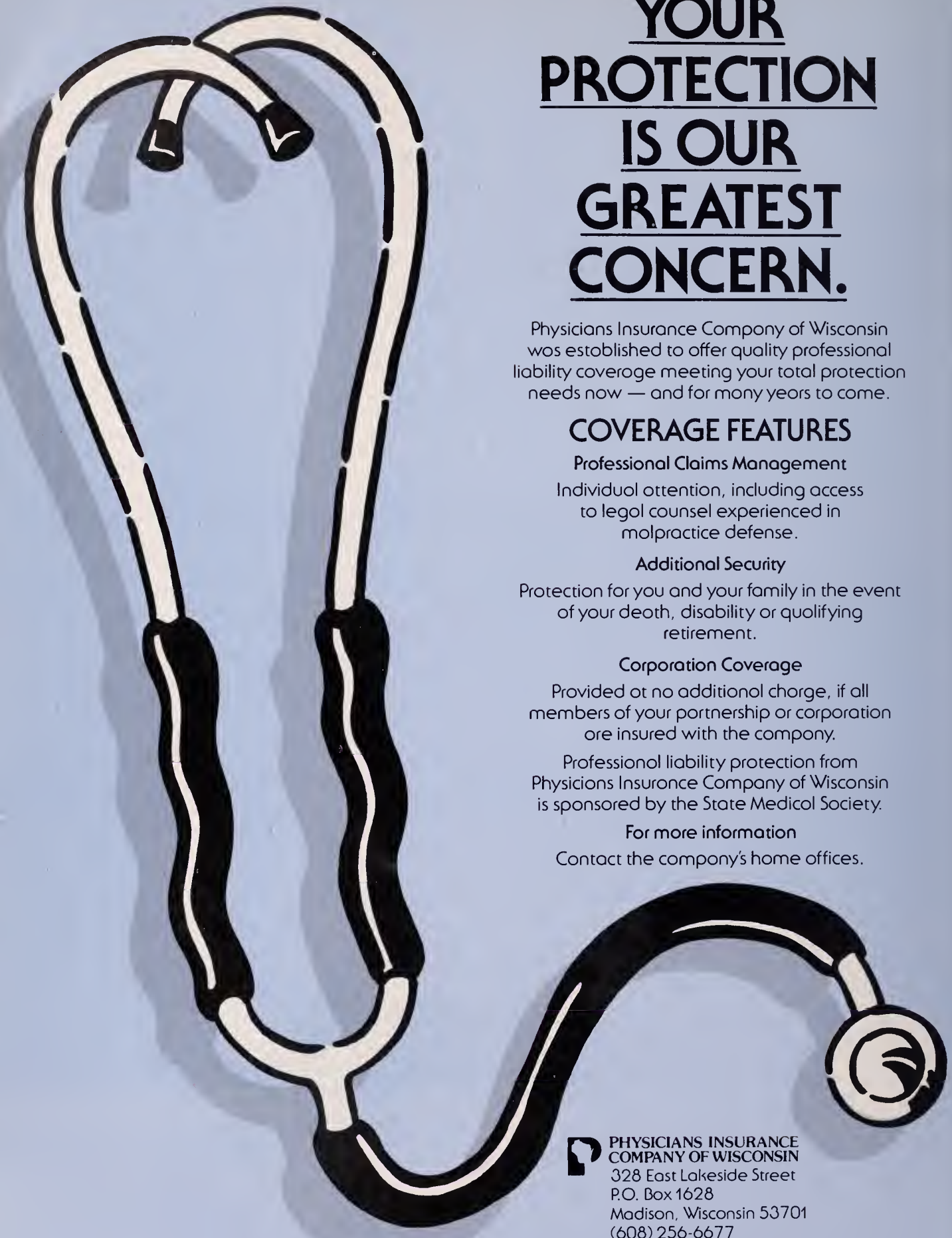
- $1.00 per physician office visit
- $1.00 per physician home visit
- $1.00 per physician in-patient hospital visit
- $1.00 per physician out-patient hospital visit
- $1.00 per physician consultation
- $3.00 per surgical procedure
- $0.50 per laboratory service performed in the physician's office
- $1.00 per radiology procedure performed in the physician's office
- $0.50 per diagnostic test

An annual $30 per recipient per physician total copayment limit for any or all of the above services will apply. Many exemptions from copayments were retained, including all services provided to recipients under age 18, pregnant women, nursing home residents, HMO enrollees, and emergency services and family planning services.

The SMS will continue working with the bureau to identify options to ease the administrative efforts of providers for collection of the new copayments. Christine Nye, bureau director, said in a letter to Mr Adams, "We will be happy to continue to work with you on additional concerns and problems as the policy is implemented."

Increase in maximum allowable fees. The Medical Assistance program has increased the maximum allowable

continued



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1-800-362-2433 (toll-free)

fees by 0.5% for physician services. These new fees are effective for dates of services on or after January 1. A copy of the 1988 maximum allowable fee schedule can be purchased after February 15 from:

Document Sales
202 S Thornton Avenue
Madison, WI 53702
Price: Approximately $30

Additional questions on either of these changes may be directed to Kit Nimtz, SMS Division of Medical Policy and Practice (800-362-9080 or 608-257-6781).■

NHSC conducts annual verification

SMS has been advised that the Wisconsin National Health Service Corps is conducting its annual verification process, in which physician's practice sites and full-time equivalent counts for Wisconsin physicians are assessed. The assessments are done both by mail and through telephone verifications.

Verified counts are used as the Wisconsin National Health Service Corps develops its annual request for review of Wisconsin's manpower shortage areas. Last summer, the Corps conducted verification by phone of physician practice locals and FTE equivalents for all physicians practicing within Wisconsin's current health manpower service areas (HMSAs) except in the Milwaukee area. The Corps is now in the process of reviewing Milwaukee and Racine counties. Clinics and hospitals in all areas of the state that are close to existing or former health manpower shortage areas will be receiving letters since verification of these areas will enhance the reliability of existing HMSA data.

Physicians with questions about the verification process for the health manpower shortage areas are encouraged to contact Richard C Heintz, Coordinator of the Wisconsin National Health Service Corps, in Madison at 608-267-7122.■

1988 ANNUAL MEETING
STATE MEDICAL SOCIETY OF WISCONSIN
AT THE MECCA, MILWAUKEE (Hyatt Hotel) • APRIL 28–30

Coordinated by the Commission on Continuing Medical Education

Kathy Belgea, MD, Scientific Program Chairman, assisted by Charles Holmburg, MD, Menomonee Falls; George Nemec, MD, Woodruff; and Thomas Meyer, MD, Madison

Two more Medicare seminars slated

Because of the popularity of the November SMS seminars on Medicare, the Society will sponsor two additional seminars in March. These seminars will be identical to the seminars held in November. The one-day seminars will cover the entire Medicare claims process for physician offices: the most common claim form errors, Medicare as a secondary payor, how to read and understand Medicare's six profiles, MAACs, special coding problems and modifiers, and the October 1, 1987, changes.

The program will feature presentations by both WPS-Medicare and SMS personnel, and will allow ample time for questions. Registration is at 8:30 a.m. The program begins at 9:00 and will conclude by 4:30 p.m. The registration fee is $40 per person, which includes lunch and materials. *Registrations will not be accepted after March 14.* Cancellations must be received in writing three days prior to each seminar to obtain a refund.

Lake Geneva	Wednesday, March 23	The Abby
Stevens Point	Friday, March 25	Holiday Inn

To register, please fill out the attached registration form for each participant and return it to SMS. If you have further questions, please contact the SMS Medical Policy and Practice Division (800-362-9080 or 608-257-6781, ext. 125). Telephone registrations will not be accepted. Attendance is limited to 125 people for each seminar, so sign up early. Confirmation letters will be mailed within two weeks of receipt of your registration.

- -

Registration Form (please print)

Name _____

Title _____

Clinic/Organization _____

Is your physician an SMS member? ____ Yes ____ No

Address _____
City Zip

Telephone Number ( ) _____

I am interested in attending the Medicare seminar that will be held in: (check one)

_____ Stevens Point ____ Lake Geneva

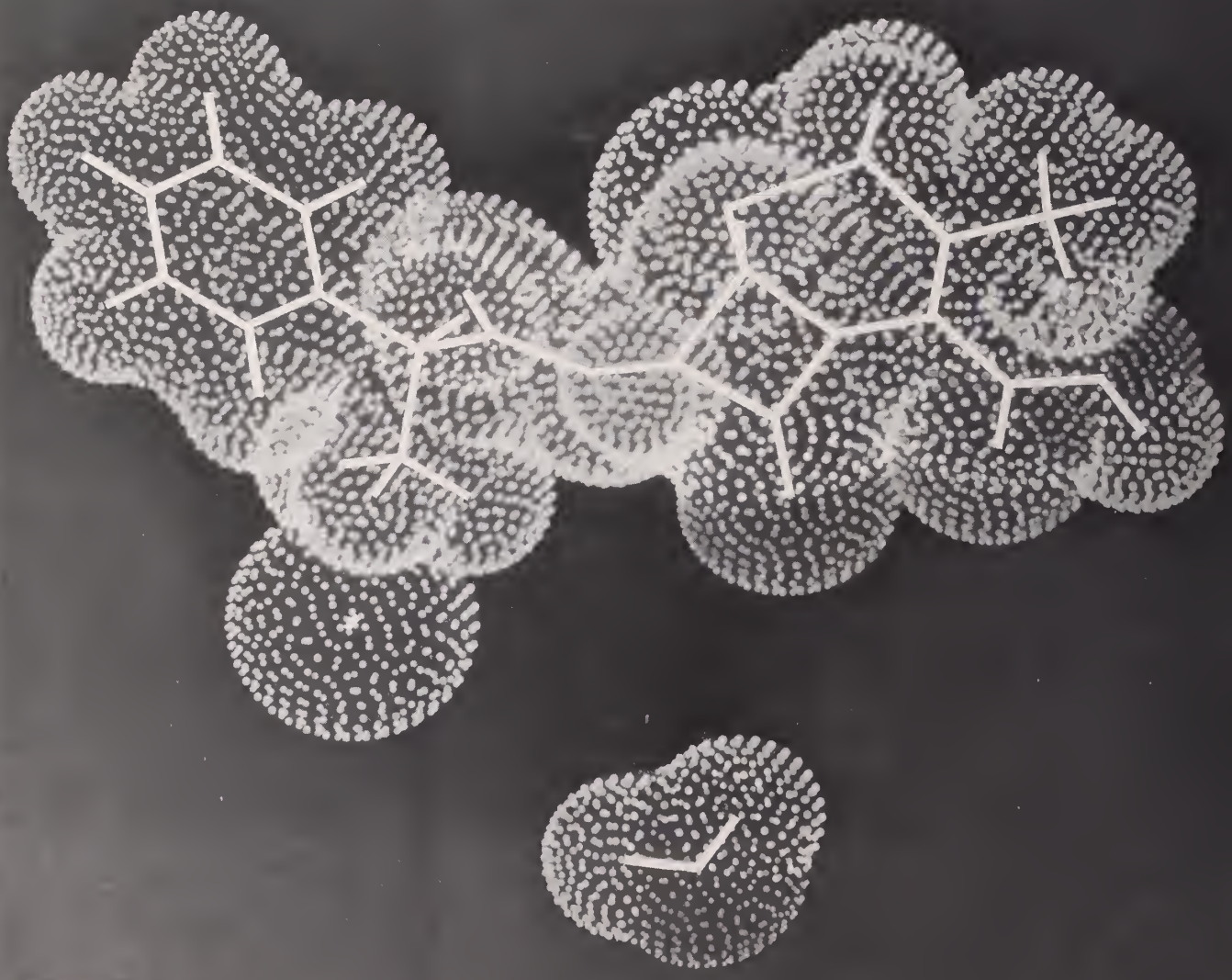
Please return registration form and $40 per person check payable to SMS to: State Medical Society of Wisconsin, PO Box 1109, Madison, WI 53701

ANNOUNCING

NEW

KEFTAB™

cephalexin hydrochloride monohydrate



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Computer-generated molecular structure of cephalexin hydrochloride monohydrate

Convenient 500-mg b.i.d. dosage and demonstrated effectiveness for treatment of:

- ☐ skin and skin structure infections*
- ☐ uncomplicated cystitis†
- ☐ pharyngitis‡

- New hydrochloride salt form of cephalexin—requires no conversion in the stomach before absorption
- Well-tolerated therapy

- May be taken without regard to meals

For other indicated infections, 250-mg tablets available for q.i.d. dosage

Priced less than Keflex® (cephalexin)

Keftab is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-sensitive patients.

Penicillin is the drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever.

*Due to susceptible strains of *Staphylococcus aureus* and/or β-hemolytic streptococci.
† Due to susceptible strains of *Escherichia coli*, *Proteus mirabilis*, and *Klebsiella* sp.
‡ Due to susceptible strains of group A β-hemolytic streptococci.

KEFTAB™
(cephalexin hydrochloride monohydrate)

Summary: Consult the package literature for prescribing information.

Indications and Usage:

Respiratory tract infections caused by susceptible strains of *Streptococcus pneumoniae* and group A β-hemolytic streptococci.

Skin and skin structure infections caused by susceptible strains of *Staphylococcus aureus* and/or β-hemolytic streptococci.

Bone infections caused by susceptible strains of *S aureus* and/or *Proteus mirabilis*.

Genitourinary tract infections, including acute prostatitis, caused by susceptible strains of *Escherichia coli*, *P mirabilis*, and *Klebsiella* sp.

Contraindication: Known allergy to cephalosporins.

Warnings: KEFTAB SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

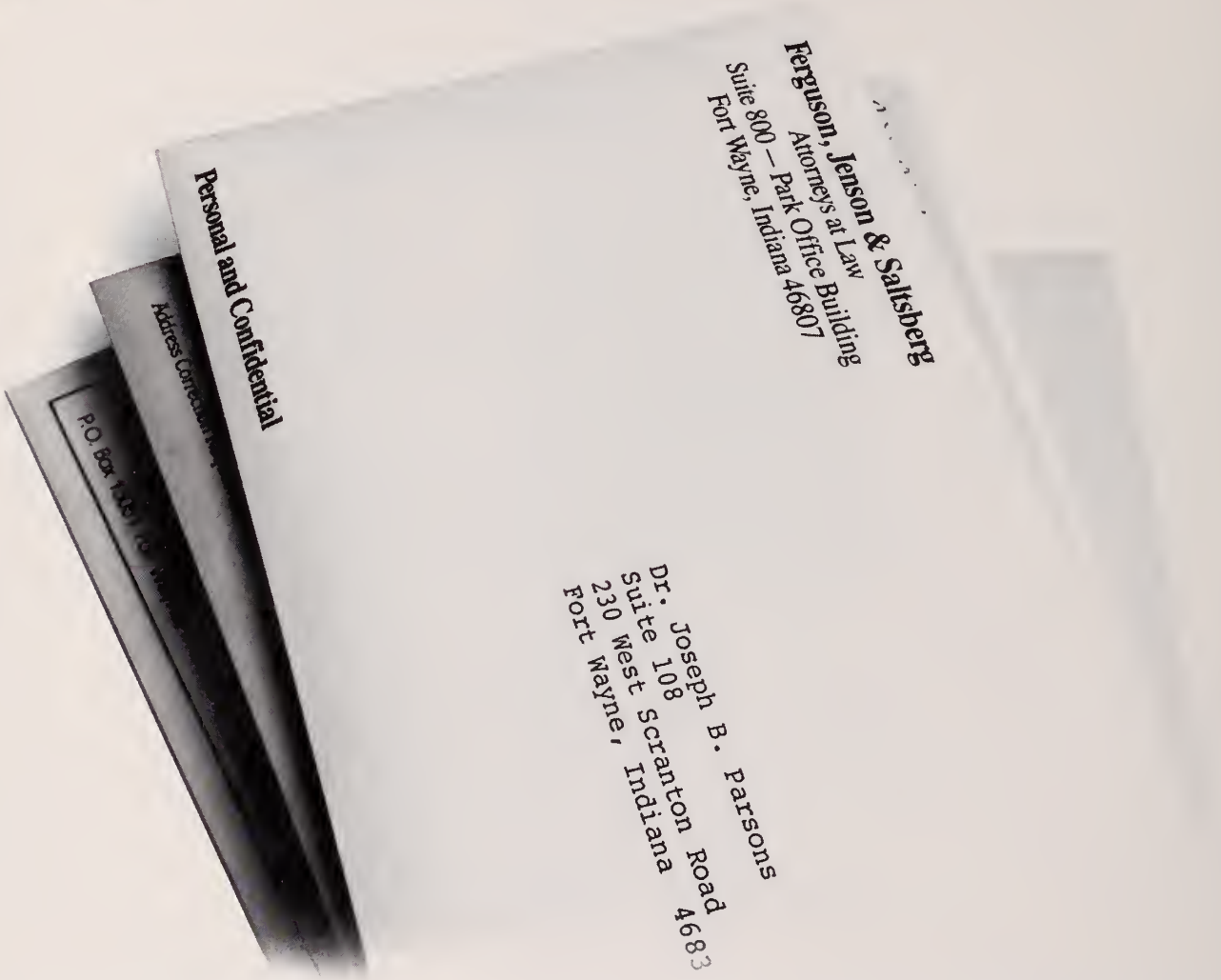
- Discontinue Keftab in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Keftab should be administered cautiously in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy and lactation. Cephalexin is excreted in mother's milk. Exercise caution in prescribing Keftab for these patients.
- Safety and effectiveness in children have not been established.

Adverse Reactions:

- *Gastrointestinal*, including diarrhea and, rarely, nausea and vomiting. Transient hepatitis and cholestatic jaundice have been reported rarely.
- *Hypersensitivity* in the form of rash, urticaria, angioedema, and, rarely, erythema multiforme, Stevens-Johnson syndrome, or toxic epidermal necrolysis.
- *Anaphylaxis* has been reported.
- *Other reactions* have included genital/anal pruritus, genital moniliasis, vaginitis/vaginal discharge, dizziness, fatigue, headache, eosinophilia, neutropenia, and thrombocytopenia; reversible interstitial nephritis has been reported rarely.
- Cephalosporins have been implicated in triggering seizures, particularly in patients with renal impairment.
- *Abnormalities in laboratory test results* included slight elevations in aspartate aminotransferase (AST, SGOT) and alanine aminotransferase (ALT, SGPT). False-positive reactions for glucose in the urine may occur with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

PV 2060 DPP [091887] 849336

Crisis in black and white.



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William E Scheckler, MD,* Madison, has been appointed by the SMS Board of Directors to serve as the Society's representative to the Public Health Advisory Forum of the Division of Health. He replaces J D Kabler, MD,* Madison, SMS president-elect.

Mark A Meier, MD,* Hales Corners, recently joined Whitnall Family Practice in Hales Corners. Doctor Meier graduated from the Pritzker School of Medicine of the University of Chicago. He completed his family practice residency program at St Luke's Hospital in Milwaukee. Doctor Meier is a member of the American College of Sports Medicine as well as the American Running and Fitness Association.

Kevin Kellogg, MD, recently became associated with Sik Q Jew, MD* in the Department of Neurology at The Monroe Clinic. He graduated from the University of Illinois at Chicago and served an internship at Tulane University-Charity Hospital. He completed a neurosurgical residency at Loyola University of Chicago and a neurology residency at Harbor-UCLA Medical Center in Los Angeles.

Philip Jacobi, MD, Eau Claire, associated with the Eau Claire Family Medicine Clinic, recently became a member of the medical staff of Sacred Heart Hospital in Eau Claire. Doctor Jacobi graduated from the University of Wisconsin Medical School, Madison, and completed his family practice residency at Sacred Heart and Luther hospitals in Eau Claire.

Bradley C Hiner, MD, Marshfield, joined the medical staff of the Marshfield Clinic in the Department of Neurology. Doctor Hiner graduated from Ohio State University College of Medicine in Columbus and completed his neurology residency at Stanford University Medical Center in California. He also completed a fellowship in basic science neurophysiology and neuropharmacology at the Veterans Administration Medical Center in Palo Alto, CA.

Bethann Bonner, MD,* La Crosse, recently became associated with the Gundersen Clinic, Ltd in the Department of Pediatrics. Doctor Bonner graduated from the Medical College of Wisconsin, Milwaukee, and completed her pediatric residency at Gundersen Medical Foundation-Lutheran Hospital in La Crosse.

Robert A Narotzky, MD,* neurosurgeon affiliated with the Midelfort Clinic, Eau Claire, has joined the medical staff of the Bloomer Hospital in Bloomer. Doctor Narotzky is Board-certified and completed his residency at Mayo Graduate School of Medicine in Rochester, MN.

Correction. In the December 1987 issue of the *Wisconsin Medical Journal* under "Physician Briefs," it was reported that Robert J Swan, MD* and Gregory J Anderson, MD* had joined the Marshfield Clinic. It should have read they joined the Midelfort Clinic in Eau Claire.

Eliot J Lewit, MD,* Eau Claire, has become associated with the Bloomer Hospital in Bloomer. A graduate from Rush Medical College, Chicago, Doctor Lewit completed his residency at Northwestern University in Evanston. He is a member of the Ihle Clinic, Eau Claire, in the Department of Neurology.■

AMA Physician's Recognition Award Recipients

LISTED BELOW are those physicians in Wisconsin who have earned the AMA Physician's Recognition Award in recent months. The State Medical Society of Wisconsin congratulates these physicians who have distinguished themselves and their profession by their commitment to continuing education:

DECEMBER 1987

*Anderson, Charles J, Madison
*Andrew, Mark H, Viroqua
Badr, M Safwan, Madison
*Bartlett, David H, Madison
*Brister, G H, Wausau
*Crummy, Andrew B, Madison
*Diancin, Renato C, Beaver Dam
*Errico, Charles A, Green Bay
Graziano, Franklin M, Madison
*Hendrix, Lloyd E, Menomonee Falls
*Huberty, Lee H, Kenosha
*Humphreys, Chris E, Eau Claire
*Ketterhagen, James P, Milwaukee
*Lerner, Neil A, Milwaukee
*Lleva, Florentino E, Arcadia
*Luetzow, Thomas J, Larsen
*Paulson, John K, Stevens Point
*Pengtovong, Lerthai, Fond du Lac
*Pinkus, Walter H, Racine
*Plouff, Louis T, Appleton
Russell, Elizabeth B, Milwaukee
*Samter, Thomas G, Whitefish Bay
*Schumacher, Bernhard J, Oconomowoc
*Stratta, Robert J, Madison
*Tilleson, Scott J, Hales Corners
*Wetzler, Robert J, Burlington
Zimmer, Herbert J, Milwaukee■

Members of the State Medical Society of Wisconsin

Membership facts

Whether you're just starting medical school, maintaining a full-time practice, or retiring, SMS has a membership classification to fit your individual needs. Election to membership by the County Medical Society in which your principal place of practice is located carries with it membership in the State Medical Society of Wisconsin and, if you wish, the American Medical Association. If you qualify for resident membership at the time of your election, your membership dues are greatly reduced. This may also qualify you for reduced dues the first two years of your practice. In addition, two-physician families may be eligible for a $50 discount on total SMS membership dues. Dues for regular membership in 1988 are $480 for SMS, $375 for AMA, and county society dues vary. A more detailed listing of SMS membership classifications and their corresponding dues follows:

State Medical Society of Wisconsin

DESCRIPTION OF MEMBERSHIP CLASSIFICATIONS

Regular: Member in active practice. • ***First year in practice***—physicians elected to SMS membership within six months of completing residency, fellowship, or fulfillment of government obligation enjoy a dues reduction of 50 percent for the first year. • ***Second year in practice***—physicians who quality by meeting the above criteria enjoy a 25 percent dues reduction during their second year of practice. • ***Two-physician family***—one member (spouse) of a two-physician family is entitled to a dues reduction of $50 or the amount of their State Society dues whichever is less.

Resident: Physician who at January 1 of dues year is in an approved training program as a hospital resident or research fellow who is licensed to practice medicine and surgery in Wisconsin.

Military Service: Members who are serving in the U.S. armed forces or Public Health Service (generally not to exceed five years).

Associate: Member whose dues are waived because of financial hardship due to illness or disability. This classification is temporary and is reviewed on an annual basis.

Life: Member who has held membership in a state medical society for 50 years or is a Past President of the State Medical Society of Wisconsin.

Honorary: Member who was named by the Board of Directors in recognition of long and distinguished service to the cause of medicine.

Retired: Member who has completely retired from practice (works less than 240 hours per year). All dues are waived unless county society indicates they wish to charge county dues.

Part-time Practice: Physician, regardless of age, who practices 1,000 hours or less during the calendar year but does not qualify for retired membership.

Over Age 70: Member in active practice who is over 70 years of age as of January 1.

Candidate: Member attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure.

Scientific Fellow: The Board of Directors may by invitation and unanimous consent confer upon any person engaged in teaching of or research in one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy, the status of Scientific Fellow.

Emeritus: Retired members who have chosen not to renew their license.

1988 DUES AMOUNTS FOR THESE CLASSIFICATIONS

	SMS	AMA	COUNTY
Regular	$480.00	$375.00	Normal County Dues
1st Year in Practice	$240.00	$187.00	Normal County Dues
2nd Year in Practice	$360.00	$281.00	Normal County Dues
Two Physician Family	$430.00	$375.00	Normal County Dues
Part-Time Practice	$240.00	$375.00/-0-	Normal County Dues
Part-Time—Over Age 70	$240.00	$187.00*	Normal County Dues
Resident	$ 48.00	$ 45.00	Varies
Military Service	-0-	$250.00/$45.00	-0-
Associate	-0-	-0-	-0-
Retired	-0-	$375/$75/-0-*	-0-
Retired—Over Age 70	-0-	-0-	-0-
Life	-0-	$375.00/-0-*	-0-
Honorary	-0-	$375.00/-0-*	-0-
Over Age 70	$240.00	$375.00/-0-*	Normal County Dues
Candidate—			
Student	[1]$ 10.00	[2]$ 20.00	-0-
Postgraduate—One	$ 10.00	$ 45.00	Varies
Scientific Fellow	-0-	-0-	-0-
Emeritus	-0-	-0-	-0-

[1]Students' SMS and County Dues for four academic years.
[2]Students' AMA Dues for the calendar year 1988

* Physicians in these categories may be eligible for exemption from paying AMA dues under the grandfather clause.

AMA dues-exempt members who were granted exemption before 1986 based on previously established criteria with the exception of financial hardship or disability will automatically be dues-exempt in 1986 and beyond under the grandfather clause.

Under new AMA policy, only the following two categories of physicians will qualify for new dues exemption:
(1) Financial hardship and/or disability
(2) 70 years of age or older *and* fully retired

Under age 70 and fully retired AMA dues may be reduced to $75.00.

Your membership in organized medicine . . .

. . . will help ensure the continued "safety" of your practice and quality care for all patients. Your voice *will* be heard through participation. Membership in the State Medical Society of Wisconsin also requires membership in the county medical society (AMA membership is optional but encouraged). For Regular, Part-time Practice, or Over Age 70 membership classifications, dues may be paid in one lump sum or in two equal installments: one-half of the total payable by January 1, the other half not later than May 15, 1988 which is the removal date for those members who have not completed payment. You are urged to renew your membership.

State Society dues are prorated on a monthly basis for those elected to membership July 1 through September 30. Those elected after September 30 have no dues payable for the balance of the year in which they are elected. AMA dues follow the same pattern except prorating is on a semiannual basis rather than monthly basis.

To begin the membership process, if your practice is or will be located in Wisconsin, or you have any questions, you may contact your local county society or call the Membership and Communications Division of the State Medical Society, if in Wisconsin: 1-800-362-9080 (Madison area number: 257-6781).■

*Physician members of the State Medical Society of Wisconsin

NEWS HIGHLIGHTS

Edgerton Clinic and the **Shearer-Cohen Clinic**, both of Edgerton, recently merged and also became affiliated with the Janesville Riverview Clinic. When remodeling and construction is completed, both units will be in a single clinic building. It will be designated Riverview Clinic–Edgerton. The Milton satellite office of the two Edgerton groups will continue unchanged and will be called Riverview Clinic–Milton. The history of physicians in Edgerton dates back to 1910 when the late A T Shearer, MD was the first in a series of physicians, including several family members, who have maintained continuity more than 75 years.

Memorial Hospital's medical staff in Oconomowoc has elected Michael J Rietbrock, MD* chief-of-staff for a two-year term. Other MDs elected to offices are Michael G O'Mara,* vice-chief-of-staff; Palmira A Janusonis,* secretary-treasurer; and Dan T Cleary,* John L Claude,* Dale A Johnson,* and Donald K Shaw* have been appointed to serve on the executive committee.

Watertown Memorial Hospital's medical staff has elected the following MDs to office for the year 1987–1988. They are Frederick C Gremmels, DO,* president; Edward J Hoy, MD,* vice president; and Michael A Grajewski, MD,* secretary-treasurer. In addition, Dr Eugene P Schuh* and Dr Ann M Tousignant* were elected to the executive committee.■

*Physician members of the State Medical Society of Wisconsin

COUNTY SOCIETIES

BROWN: Fifty-seven members attended the November Brown County Medical Society meeting. Paul Markowski, new member of the SMS Division's Medical Society Relations (MSR) staff, was introduced at the meeting and answered questions on the medical liability problem. Fred Walburn, MD,* introduced the speaker, Mark Seigler, MD, Chicago, Illinois, who spoke on issues related to the care of the elderly.

BROWN: Seventeen members and one guest were present at the December meeting of the Brown County Medical Society held in Green Bay. Wesley E McNeal, MD,* president, opened the meeting and commented on an item having to do with renewed efforts by the County Society to establish contact with the business community. Applications for membership were approved for Fawzi A Jamra, MD* and Joan Handeland, MD* both of Green Bay. Guest speaker was Gregg E Simmons, Madison, chief executive officer of WIPRO in Madison, who discussed several aspects of WIPRO in its operation and answered questions. Herbert F Sandmire, MD,* questioned the status of the Green Bay Health Care Coalition and there was some discussion regarding proposals by the Health Care Coalition to obtain data that would allow them to make decisions about the cost of healthcare in Brown County. President McNeal closed his term of office with a thoughtful and thought-provoking speech.

OUTAGAMIE: Fourteen members were present at the Outagamie County Medical Society to hear State Representative David Prosser speak on "Current Medical Issues in the State Legislature."

Kenneth M Viste Jr, MD,* *Oshkosh, president of the State Medical Society, is shown above (right) with* **Brian D Wake, MD,*** *Sturgeon Bay, president of Door-Kewaunee County Medical Society. Doctor Viste spoke at the December meeting of the County Society on the State Medical Society's Partner-Care program. (Photo courtesy of Linda Adams of the* **Advocate**)■

OBITUARIES

A Allen Sverdlin, MD, 79, Fox Point, died Oct 12, 1987 in Milwaukee. Born Sept 5, 1908 in Milwaukee, Doctor Sverdlin graduated from Marquette University School of Medicine in 1935 and completed his internship at St Joseph's Hospital in Marshfield. He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association. Surviving are his widow, Bess; and one son, Michael of Fox Point.

Harry L Schwartz, MD, 78, Kenosha, died Oct 27, 1987 in Kenosha. Born May 10, 1909 in Pipestone, MN, Doctor Schwartz graduated from Northwestern Medical School, Evanston, IL, and served his internship at Presbyterian Hospital in Chicago. Doctor Schwartz had practiced medicine in Kenosha from 1935 until his retirement in 1981. He was a member and past president of the Kenosha County Medical Society, and a member of the State Medical Society of Wisconsin and American Medical Association. Surviving are his widow, Sarah; one son, Harry L, Kenosha; three daughters, Mary Ann Rademacher, Hillsboro, IL; Nancy Johnson, Hickory, NC; and Elizabeth Stephenson of Middleton, IL.

J Stan Hashimoto, MD, 44, Marinette, died Oct 28, 1987 in Marinette. Born Oct 9, 1943 in Manzanar, CA, Doctor Hashimoto graduated from Loyola Stritch School of Medicine, Chicago, IL, and served his internship and residency at Great Lakes Naval Hospital in Illinois. Doctor Hashimoto had been associated with the Boren Clinic (now Marinette-Menomonee Clinic) as an obstetrician. He was a member of the Marinette County Medical Society, State Medical Society of Wisconsin, and American Medical Association. Surviving are his widow, Frances; one son, David; and a daughter, Amy, both at home.

Carlyle R Pearson, MD, 82, Baraboo, died Nov 25, 1987 in Baraboo. Born Sept 28, 1905 in Two Rivers, Doctor Pearson graduated from the University of Wisconsin Medical School, Madison, and served his internship at Kansas City General Hospital. His residency in surgery was completed at the University of Wisconsin in Madison. Doctor Pearson had served as chief-of-staff and as chief of surgery at St Clare Hospital in Baraboo. He was a member of the Railway Surgeons Association; a member and past president of the Sauk County Medical Society; a member of the State Medical Society of Wisconsin and American Medical Association. Surviving are his son, Scott, Palo Alto, CA, and a daughter, Mrs Janet Brown of Evanston, IL.

Robert Lee Brisbin, MD, 56, San Diego, CA, died Dec 1, 1987 in San Diego, CA. Born Dec 12, 1930 in Pittsburgh, PA, Doctor Brisbin graduated from the University of Wisconsin Medical School, Madison, and served an internship at the Philadelphia General Hospital. His residency in surgery was completed at the US Naval Hospital in Portsmouth, VA. Doctor Brisbin served in the United States Navy for 20 years retiring in 1976. He joined the Smith-Hanna Medical Group in San Diego and had been affiliated with the Sharp Medical Hospital, Mercy Hospital, and Children's Hospital. He also was an assistant clinical professor of surgery at the University of California at San Diego. He is survived by his widow, Joan; and three sons, Scott, Kent, and Kirk.

Clement LeRoy Lacke, MD, 86, Madison, died Dec 4, 1987 in Madison. Born Feb 9, 1901 in Highland, WI, Doctor Lacke graduated from the University of Wisconsin Medical School, Madison, and served his internship and residency at St Marys Hospital Medical Center in Madison. He practiced medicine in Madison until 1960 when he retired from his medical practice and became associated with the Dane County Health Department for a number of years. He was a member of the Dane County Medical Society, State Medical Society of Wisconsin, and American Medical Association. Surviving is his widow, Grace of Madison.

Moira J Whitehead-Thorne, MD, 30, McMurray, PA, died Dec 12, 1987 in McMurray, PA. Born Dec 6, 1957 in Appleton, Doctor Whitehead graduated from the University of Wisconsin Medical School, Madison, and served her residency at Children's Hospital of Pittsburgh. Surviving are her husband, Peter S Thorne; a son, Alexander of McMurray, PA; and her parents, Mary and Howard Whitehead of Appleton.

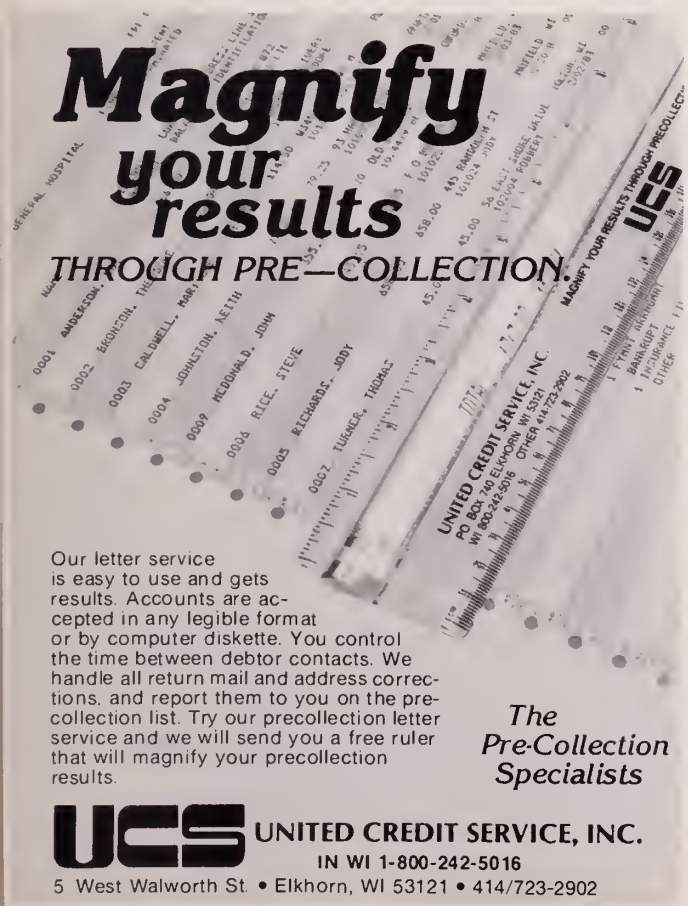
Ruth Bleier, MD, 65, Madison, died Jan 4, 1988 in Madison. Born Nov 17, 1923 in Pittsburgh, PA, Doctor Bleier graduated from Woman's Medical College of Pennsylvania and served her internship at Sinai Hospital in Baltimore, MD. Doctor Bleier was a professor of neurophysiology and women's studies at the University of Wisconsin, Madison.■

Impaired Physician

Persons interested in the Impaired Physician Program may call 608/257-6781 or toll-free in Wisconsin: 1-800-362-9080 and explain their concern to John LaBissoniere, Sally Wencel, or H B Maroney of the State Medical Society staff. The caller's identity will be kept in complete confidence.

Prenatal viral exposure and schizophrenia risk

Prenatal viral infection may raise the risk of adult schizophrenia, a report in the February 1988 issue of *Archives of General Psychiatry* says. Sarnoff A Mednick, PhD, DrMed, of the University of Southern California, Los Angeles, and colleagues reviewed psychiatric hospital diagnoses for Helsinki, Finland-area adults who were fetuses during a 1957 type A2 influenza epidemic. Those exposed to the epidemic in the second trimester of fetal development were at greater risk of later schizophrenic diagnosis; this held for both sexes and was seen in several hospitals independently. The authors note several study limitations, including no direct evidence that subjects had a viral infection, but say this "should not serve to enhance the findings." They consider the observed viral effect "one of many potential perturbations of gestation," concluding, "it is less the type than the timing of the disturbance during fetal neural development" that is key to determining schizophrenia risk.—*AMA Brief Report*■



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INDICATIONS AND USAGE: BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis, in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2. For the prevention of potassium depletion when the dietary intake is inadequate in the following conditions: Patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, and with certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS: Potassium supplements are contraindicated in patients with hyperkalemia since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: Chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene).

Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to enlarged left atrium.

All solid dosage forms of potassium chloride supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation.

WARNINGS: Hyperkalemia—In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic. The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction with Potassium Sparing Diuretics—Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene) since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions—Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage or perforation.

K-DUR tablets contain micro-crystalloids which disperse upon disintegration of the tablet. These micro-crystalloids are formulated to provide a controlled release of potassium chloride. The dispersibility of the micro-crystalloids and the controlled release of ions from them are intended to minimize the possibility of a high local concentration near the gastrointestinal mucosa and the ability of the KCl to cause stenosis or ulceration. Other means of accomplishing this (e.g., incorporation of potassium chloride into a wax matrix) have reduced the frequency of such lesions to less than one per 100,000 patient years (compared to 40–50 per 100,000 patient years with enteric-coated potassium chloride) but have not eliminated them. The frequency of GI lesions with K-DUR tablets is, at present, unknown. K-DUR tablets should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis—Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, potassium acetate, or potassium gluconate.

PRECAUTIONS: The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium. The treatment of potassium depletion, particularly in the presence of cardiac disease, renal disease, or acidosis requires careful attention to acid-base balance and appropriate monitoring of serum electrolytes, the electrocardiogram, and the clinical status of the patient.

Laboratory Tests: Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions: Potassium-sparing diuretics; see **WARNINGS.**

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C: Animal reproduction studies have not been conducted with K-DUR. It is also not known whether K-DUR can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. K-DUR should be given to a pregnant woman only if clearly needed.

Nursing Mothers: The normal potassium ion content of human milk is about 13 mEq per liter. Since oral potassium becomes part of the body potassium pool, so long as body potassium is not excessive, the contribution of potassium chloride supplementation should have little or no effect on the level in human milk.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: One of the most severe adverse effects is hyperkalemia (see **CONTRAINDICATIONS, WARNINGS,** and **DVERDDSAGE).** There have also been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see **CDNTRAINDICATIONS** and **WARNINGS);** other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose

Skin rash has been reported rarely.

DVERDOSAGE: The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see **CONTRAINDICATIONS** and **WARNINGS**). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration and characteristic electrocardiographic changes (peaking of T-waves, loss of P-waves, depression of S-T segment, and prolongation of the DT-interval). Late manifestations include muscle-paralysis and cardiovascular collapse from cardiac arrest.

Treatment measures for hyperkalemia include the following:

1. Elimination of foods and medications containing potassium and of potassium-sparing diuretics.

2. Intravenous administration of 300 to 500 ml/hr of 10% dextrose solution containing 10–20 units of insulin per 1,000 ml.

3. Correction of acidosis, if present, with intravenous sodium bicarbonate.

4. Use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia, it should be recalled that in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity

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BC/BE General Internist to join 26-MD multispecialty group with four internists, one nephrologist and one gastroenterologist. Top salary first year, full incentive thereafter. Central Wisconsin university town with drawing area of 80,000. Send CV to Dr John Gauder, Rice Clinic, SC, 2501 Main St, Stevens Point, WI 54481, or call collect 715/344-4120. 12tfn/87

General Surgeon. Board-certified general surgeon needed to join expanding 85-physician multispecialty medical center in Los Angeles and Orange counties. An exceptional base salary and incentive plan. Benefits include malpractice insurance, group health and life insurance. Please send CV to Dept 604 in care of the Journal. 12/87;1-2/88

Neurologist. Experienced neurologist needed to join expanding 85-physician multispecialty medical center in Los Angeles and Orange counties, with existing neurological practice. An exceptional base salary and incentive plan. Benefits include malpractice insurance, group health and life insurance. Please send CV to Dept 605 in care of the Journal. 12/87;1-2/88

Internal Medicine. Six physician general internal medicine practice in Duluth seeks BC/BE internist to replace retiring senior partner in their busy group. Competitive guaranteed salary and fringe benefits. Call or write L Timothy Knutson, Medical Resource Group, Inc, 2550 University Avenue, W, Suite 239, St Paul, MN 55114; ph 612/647-0003. p12/87; 1-2/88

RATES: 50¢ per word, with a minimum charge of $20.00 per ad. BOXED AD RATES: $25.00 per column inch. *All ads must be prepaid.*

DEADLINE: Copy must be received by the 15th of the month preceding month of issue; *eg*, copy for the August issue is due July 15. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 1-800-362-9080.

Primary Care Physician—Family Practice, General Practice, or ER experience desirable, to staff urgent care clinic on part-time or full-time basis. Excellent opportunity including guaranteed salary, profit-sharing, excellent fringe benefits, and stockholdership. Send CV to Louis C Bernhardt, MD, Chairman, Recruiting Committee, Dean Medical Center, 1313 Fish Hatchery Rd, Madison, WI 53715. Equal Opportunity/Affirmative Action Employer. p2-3/88

Lucrative Practice Opportunity for all medical and surgical specialties: especially FP, Dermatology, EENT, Ortho, Radiology, Pathology, OB, General Surgeons, PAs, Nurse Practitioners, Independent or Group Practice. Full-time/part-time/once-a-week or "moonlight." Multiple investment opportunities available. All options open for your advantage. Also, excellent Tax Shelter opportunities in a major sports and recreational region for "visiting physicians." Accommodation provided. Visit/call Farukh Khan, MD, Golden Medical & Surgical Center, Elkins, WV 26241; ph 304/636-5426. 2-4/88

BC/BE General Surgeon. Outstanding opportunity for general surgeon to associate with two active internists in a friendly rural community in Northeastern Wisconsin near Green Bay. New clinic attached to a 55-bed community hospital. Excellent long-term growth potential. Send CV to Artwich Clinic, Ltd, 815 South Main St, Oconto Falls, Wis 54154. p2-4/88

BC/BE Internist. Outstanding opportunity for general internist to join two active internists in a busy practice of internal medicine in a friendly rural community in Northeastern Wisconsin near Green Bay. New clinic attached to a 55-bed community hospital with new ICU/CCU. Excellent long-term growth potential. Send CV to Artwich Clinic, Ltd, 815 South Main St, Oconto Falls, Wis 54154. p2-4/88

Family Practitioner. Clinic seeking a well-rounded physician to practice at a growing established satellite clinic 30 miles north of main clinic. Clinic located in a friendly rural community with year-round outdoor activities. Send CV to Artwich Clinic, Ltd, 815 South Main, Oconto Falls, Wis 54154. p2-4/88

General Surgeon. Medium-sized acute care hospital level one Trauma Center, located in northern Illinois, seeks general surgeon and surgery residents, minimum 4 years residency training, for in-house surgical trauma coverage. Flexible scheduling primarily weekends. Competitive salary. Send CV to Dept 610 in care of the Journal. 2-4/88

Family Practice. Unique opportunity in outpatient family medicine. Marshfield Clinic is seeking a Board-certified/eligible family practitioner to join its expanding center in Mosinee, Wisconsin. The Center is currently staffed by three family practitioners and a physician's assistant. Full specialty consultation is readily available. Emphasis on quality lifestyle is combined with excellent compensation and fringe benefits. Send curriculum vitae and references to Richard G Nash, MD, 607 13th St, Mosinee, WI 54455 or call collect to 715/693-6711. 2/88

Family Medicine. Outstanding, diversified family practice opportunity in attractive riverfront community offering the support and resources of a major group with the autonomy of private practice. Competitive salary with productivity bonus and extensive benefits package along with paid interview and relocation expenses. Call Robert A Douglas, MD at 1-800/327-1585. 2/88

Wisconsin. OB/GYN (BC/BE) needed to join dynamic HMO-based multispecialty group practice. University town of 55,000 near Minneapolis. Community and recreation outstanding. Competitive salary and fringes. We take pride in our patient care. Contact: Robert A Braastad, MD, Group Health Cooperative, 1030 Regis Court, Eau Claire, WI 54701; ph 715/836-8552. p12/87;1-4/88

Family Practice. Marshfield Clinic Department of Family Medicine has an opportunity for a BE/BC family practice specialist to join its six-member group. This position offers a high quality fulfilling practice with both inpatient and outpatient responsibilities. This physician would enjoy the support of one of the nation's largest multispecialty groups. Unique rural setting, excellent salary, plus extensive fringe benefits. Reply with CV to Steven M Fontanini, DO, Chairman, Department of Family Practice, Marshfield Clinic, 1000 North Oak Ave, Marshfield, WI 54449 or call collect 715/387-5168. 2/88

Orthopedic Surgeon. Board-certified/Board-eligible to join a 23-physician multispecialty group in Winona, Minnesota. Total patient population draw area of 40,000. Interested physicians please contact J B Knuesel, Administrator, Winona Clinic, Ltd, 420 East Sarnia, Winona, MN 55987. 2-4/88

For Emergency Physician who possesses excellent clinical and trauma skills within a group of 7 Emergency Room physicians located in beautiful northwest Wisconsin area. Please send CV to: Dr M Jaghlit, 900 W Clairemont Ave, Eau Claire, WI 54701 or call 715/839-4404. 9-12/87;1-2/88

PHYSICIANS EXCHANGE

continued

Dermatologist, Pediatrician, Oncologist, Pathologist, Otorhinolaryngologist, Psychiatrist, Endocrinologist, Orthopedist, General/Family Practitioner. Excellent opportunity for physicians in Los Angeles suburb to join 90-member multispecialty medical group. Large fee-for-service and prepaid practice, no Medi-Cal. Excellent compensation program based on guarantee plus incentive, profit-sharing and pension plan. Group provides health, dental, life, and malpractice. Partnership in real estate and medical corporation available. Send CV to Ron McDaniel, Assistant Administrator, Mullikin Medical Center, 17821 S Pioneer Blvd, Artesia, CA 90701. 12/87;1-2/88

Pediatrician to join existing two-person practice at the 23-physician multispecialty Winona Clinic, Ltd, in Winona, Minnesota. Located in the beautiful Mississippi River Valley of southeast Minnesota. The community with a 40,000 population trade area is the host of three colleges and a diverse industrial base. Send CV to J B Knuesel, Administrator, Winona Clinic, Ltd, 420 East Sarnia, Winona, MN 55987. 2-4/88

Internal Medicine. Board-certified or eligible to join four general internists in a multispecialty group in northeastern Wisconsin. Office is next to two hospitals. Partnership is available after one year. Send CV to Dept 596 in care of the Journal. p8-12/87; 1/88; 2-4/88

General Internist. Board-certified or Board-eligible for acute medical care position. Also provides coverage in expanding Medical Outpatient Unit. Competitive base salary plus VA Physicians Special Pay. Thirty days paid vacation; Federal malpractice protection; institution approved Category I CMEs; relocation expenses; other Federal service fringe benefits. Tomah is a progressive city of 7500 located in west central Wisconsin. Predominantly rural setting offers four season outdoor recreation, clean air, good schools, and affordable housing. Call or send CV: K S Prathipati, MD, Chief Medical Service (118), VA Medical Center, Tomah, WI 54660; 608/372-3971, ext 307. EO/AAE. 1-2/88

Baraboo, Wisconsin. Emergency Department at St Clare Hospital seeks full and part-time physicians. Eight thousand annual visits. Hourly compensation. Pleasant area in which to live, near Devil's Lake, and the Baraboo Hills. Also, Madison nearby. Contact: Mr Ronald Levy, Executive Director, St Clare Hospital, 707 14th St, Baraboo, WI 53913; ph 608/356-5561. p1/88;2/88

Green Bay, Wisconsin. Twenty-eight physician multispecialty group seeking BC/BE physicians in the following specialties: Family Practice, Pulmonology, Pediatrics, ENT, and Anesthesiology. Green Bay is a progressive community with an easy lifestyle, ample outdoor activities, excellent schools and cultural activities. The Clinic offers competitive salary and excellent fringe benefits. Please send CV to: P M Kindrachuk, Administrator, West Side Clinic, sc, Post Office Box 19070, Green Bay, WI 54307-9070. 12/87;1-3/88

Primary Care Physicians—Family Practice, General Practice, or ER experience desirable. To staff clinics for industrial, walk-in, after hours, and satellite medicine. Excellent opportunity—guaranteed salary, profit-sharing, great fringes. Send CV to Administrator, Manitowoc Clinic, PO Box 3008, Manitowoc, WI 54220. p7-12/87; 1-5/88

Internal Medicine physician Board-certified/Board-eligible to join 23-physician multispecialty group in Winona, Minnesota, with existing nine-physician Internal Medicine Department. Total draw of 40,000 population. Competitive salary offered. Interested physicians please contact J B Knuesel, Administrator, Winona Clinic, Ltd, 420 East Sarnia, Winona, MN 55987. 2-4/88

New Physicians for Wisconsin
is seeking
PRIMARY CARE PHYSICIANS
for numerous
Wisconsin communities
Fred Moskol
University of Wisconsin
Office of Rural Health
810 University Bay Drive
Madison, WI 53705
608/263-6690
7-12/87; 1-6/88

Beloit Clinic, SC, an expanding multispecialty group in a southern Wisconsin college town is seeking an internist, pediatrician, and family practitioner for second satellite clinic; and an additional BC/BE cardiologist and BC/BE neurologist for main facility. Guaranteed salary with incentive plus excellent fringe benefits. Send CV to James F Ruethling, Administrator, Beloit Clinic, SC, 1905 Huebbe Parkway, Beloit, WI 53511; ph 608/364-2200. 6tfn/87

Primary Care. Primary care physician to work in "Walk-In" Department of 24-physician multispecialty clinic. 12 to 15 hours per week. Excellent back-up services. Complete lab and x-ray on-site. Lodging accommodations available. Contact: Administrator, Rice Clinic, 2501 Main St, Stevens Point, WI 54481 or call collect 715/344-4120. 6tfn/87

West Bend, Wisconsin, General Clinic, a 20-physician multispecialty group is seeking additional B/C, B/E physicians in **Family Practice, Pediatrics, OB/GYN, Internal Medicine, Urology, Dermatology,** and **ENT.** First-year salary and benefits guaranteed. Corporate association after one year. Located in a family-oriented, economically strong small city surrounded by four-season recreational and scenic Kettle Moraine area 30 miles north of metropolitan Milwaukee. Contact Hans W Schmelzling, Administrator, 279 S 17th Ave, West Bend, WI 53095; ph 414/338-1123. 7tfn/87

Excellent opportunity for a Board certified or eligible **ob/gyn** to practice in conjunction with a 4-member OB/GYN Department of a 28-member multispecialty group. The group is located in southeastern Wisconsin, in a city of 100,000 between two major metropolitan areas. If interested, please send CV to: William H Olson, Kurten Medical Group, 2405 Northwestern Ave, Racine, WI 53404. All inquiries will be kept confidential. 5tfn/86; c1tfn/88

Physicians needed full- or part-time to perform light physicals. Milwaukee area. Professional liability provided. Phone 414/344-2100, Ms Jenkins. 10tfn/84

Family Practice—Madison, Wisconsin. Eleven-year-old staff model HMO has a family practice position available. We offer a very attractive practice setting with reasonable scheduling, excellent salary and benefits. Contact: John Hansen, MD, Medical Director, Group Health Cooperative, One South Park, Madison, WI 53715; ph 608/257-9700. 1-3/88

Urologist physician Board-certified/Board-eligible to join 23-physician multispecialty group in Winona, Minnesota. Total draw area of 40,000 population. Competitive salary offered. Interested physicians please contact J B Knuesel, Administrator, Winona Clinic, Ltd, 420 East Sarnia, Winona, MN 55987. 2-4/88

Eagle River—Great opportunity for two BC/BE family practice physicians to join well-established practice. Guaranteed annual income and future partnership available. For more information, send resume to Judy Harris, Recruiter, UW Office of Rural Health, 810 University Bay Dr, Madison, WI 53705 or call collect 608/263-7933. 1tfn/88

PHYSICIANS EXCHANGE

continued

Twenty-nine physician multispecialty clinic located in desirable East Central Wisconsin location is seeking Board-certified or Board-qualified orthopedic surgeon to round out its services. Lab, x-ray, excellent hospital. Liberal guarantee and benefits. If interested contact D F Sweet, MD, Fond du Lac Clinic, SC, 80 Sheboygan St, Fond du Lac, WI 54935. 9tfn/87

Physician. Excellent opportunity for a family practitioner to join multifaceted clinic in northern Wisconsin located in a recreational environment. Good benefits and competitive salary. Submit resume or call 715/799-3495. Menominee Indian Tribe, PO Box 397, Keshena, WI 54135. 12/87;1-2/88

Position Available. Industrial Medicine Group seeking 4 physicians interested in practicing comprehensive healthcare in a stable correctional health setting. Enjoy the full spectrum of general medicine in a protected environment. Quiescent rural and cultural urban positions available. Controlled hours and administrative duties. Liberal salary and benefits. For further information please send current CV to M Sorenson, Westmound Clinics, 683 Westmound Dr, Waukesha, WI 53186; ph 414/544-1300. 2-3/88

MEDICAL FACILITIES

Practice Available. Well-established Internal Medicine practice in Kenosha, WI. Office location convenient to both local hospitals. Spacious and well-equipped and suitable for one or two physicians. Contact Dept 611 in care of the Journal. p2/88

Milwaukee, Wisconsin suburban practices for sale. Primary care full practice opportunity. Hospital area. Retiring general internists. Can accommodate 1-3 physicians. Will introduce. Financial assistance available. Submit CV to PO Box 27622, Milwaukee, WI 53227. 2-3/88

MISCELLANEOUS

HOLTER MONITOR
Quality Scanning for reel or cassette type recorders by qualified technicians and certified cardiologists' interpretations, scan price $35.00 with UPS speedy delivery. Recorders loaned, leased, or purchase new dual-channel Holter recorders, $750.00, with two-year warranty. For more information call Advance Medical and Research Center 1-800/552-6753. 11tfn/85

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

WISCONSIN

MARCH 19, 1988: Wisconsin Dermatological Society, University Hospital and Clinics, Madison. 12tfn/87

APRIL 8, 1988: *Fourth Annual Duluth Heart Conference.* Sponsored by The Duluth Clinic, Ltd, and St Mary's Medical Center. Credits: AMA Category I, 6 hours; AAFP prescribed, 6 hours. Info: Barb Jablonski, Duluth Clinic Administration, 400 East Third St, Duluth, MN 55805; ph 218/722-8364, ext 710. 1-3/88

APRIL 9, 1988: *9th Annual Trauma Seminar, Occupational Injuries,* Gundersen Clinic/La Crosse Lutheran Hospital, La Crosse. Info: Darlene Kleba, Trauma and Emergency Center, La Crosse Lutheran Hospital, 1910 South Ave, La Crosse, WI 54601; ph 608/785-0530, ext. 3508. 1-2/88

APRIL 21-22, 1988: *AIDS and HIV: Issues and Answers—Medical Neuropsychiatric, Legal and Ethical,* sponsored by the Center for Affective Disorders, University of Wisconsin Department of Psychiatry, Medical School Continuing Medical Education and UW Hospitals and Clinics. AMA Category I/13 hours; AAFP elective/13 hours, and UW Continuing Education/13 hours. Contact Ann Bailey, Administrator, Continuing Medical Education, Room 456, 610 Walnut St., Madison, WI 53705; ph 608/263-2854. 2/88

APRIL 22, 1988: *Wisconsin Chapter-American Academy of Pediatrics* Annual Meeting, at the American Club, Kohler. Theme: "Renal diseases: A Wisconsin perspective on hypertension, hemolytic uremic syndrome, and primary care concerns." Contact Carl Eisenberg, MD: 414/352-3100. g11-12/87; 1-3/88

APRIL 26, 1988: *Wisconsin Academy of Ophthalmology,* held in conjunction with the Milwaukee Opthalmic Society meeting, University Club, Milwaukee. Info: 414/259-1930 (Arleen). g1-3/88

APRIL 28-30, 1988: State Medical Society of Wisconsin Annual Meeting, Milwaukee.

JUNE 2, 1988: *Gastroenterology for the Practicing Physician* at Red Carpet Hotel/Airport, 4747 South Howell Ave, Milwaukee. Sponsored by The Center for Digestive Disorders at Trinity Memorial Hospital, and Merck, Sharp & Dohme Pharmaceuticals. 9:30 am-3:30 pm. Lunch provided. No charge. Course director, Joseph E Geenen, MD. Info: James G Streed, Trinity Memorial Hospital, 5900 South Lake Dr, Cudahy, WI 53110; ph 414/769-4050. g2tfn/88*

JUNE 3-4, 1988: Wisconsin Radiological Society and the Milwaukee Roentgen Ray Society, American Club, Kohler. g11-12/87;1-5/88

JUNE 16-19, 1988: Wisconsin Academy of Family Physicians, Holiday Inn, Stevens Point. g10tfn/87

JULY 21-23, 1988: *Wisconsin Society of Obstetrics and Gynecology,* Landmark Resort, Egg Harbor. g1-6/88

JULY 29-31, 1988: Wisconsin Dermatological American Club, Kohler. 12tfn/87

AUGUST 3-8, 1988: *"International Doctors In Alcoholics Anonymous,* Stouffer Hotel, Baltimore, MD. Info: Information Secretary, IDAA, 1950 Volney Rd, Youngstown, OH 44511; ph 216/782-6216. g1-7/88

SEPT 9-11, 1988: Wisconsin Society of Anesthesiologists, Convention Center/Embassy Suites, Green Bay. g10tfn/87

SEPT 15-17, 1988: Wisconsin Society of Internal Medicine, Milwaukee Marriott. g10tfn/87

SEPTEMBER 30-OCTOBER 1, 1988: Wisconsin Radiological Society, Concourse Hotel, Madison. g11-12/87;1-8/88

OCTOBER 20-21, 1988: Wisconsin Chapter, American College of Emergency Physicians, The Abbey, Lake Geneva. 2tfn/88

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 50¢ per word, with a minimum charge of $20.00 per listing. *All listings must be prepaid.*

BOXED LISTINGS: $25.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 15th of the month preceding the month of publication; eg, copy for the August issue is due by July 15. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 1-800-362-9080.

FOR LISTING of other meetings see the July 3, 1987 issue of the *Journal of the American Medical Association:* Continuing Education Opportunities for Physicians for period September 1987 through February 1988.

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

continued

DECEMBER 10, 1988: Wisconsin Chapter, American College of Surgeons, Marc Plaza, Milwaukee. 2tfn/88

AMA

JUNE 26-30, 1988: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 4-7, 1988: Interim House of Delegates, Dallas, TX.

JUNE 18-22, 1989: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 3-6, 1989: Interim House of Delegates, Honolulu, HI.

JUNE 24-28, 1990: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 2-5, 1990: Interim House of Delegates, Orlando, FL.■

Wisconsin Specialty Society Meetings 1988

- Wisconsin Chapter-American Academy of Pediatrics Annual Meeting, American Club, Kohler, April 22, 1988.
- Wisconsin Radiological Society and the Milwaukee Roentgen Ray Society, June 3-4, 1988, American Club, Kohler.
- Wisconsin Academy of Family Physicians, June 16-19, 1988, Holiday Inn, Stevens Point.
- Wisconsin Society of Obstetrics and Gynecology, July 21-23, 1988, Landmark Resort, Egg Harbor.
- Wisconsin Society of Anesthesiologists, Sept 9-11, 1988, Convention Center/Embassy Suites, Green Bay.
- Wisconsin Society of Internal Medicine, Sept 15-17, 1988, Milwaukee Marriott.
- Wisconsin Radiological Society, Sept 30-Oct 1, 1988, Concourse Hotel, Madison.

* * *

Specialty Society Meetings to be held in conjunction with SMS Annual Meeting, April 28-30, 1988, Milwaukee

- Wisconsin Allergy Society
- Wisconsin Society of Anesthesiologists
- Wisconsin Chapter, American College of Emergency Physicians.
- Wisconsin Academy of Family Physicians
- Wisconsin Society of Pathologists
- Wisconsin Society of Physical Medicine and Rehabilitation
- Wisconsin Society of Radiation Oncologists

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State Medical Society of Wisconsin

Dates and locations of ANNUAL MEETINGS 1988-1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel, unless otherwise indicated.

1988—April 28-30
1989—April 13-15
1990—April 26-28: ***Green Bay***
Convention Center, Embassy Suites
1991—April 18-20
1992—April 23-25

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

AMA to explore the issue of physician competence

The American Medical Association will cosponsor a national conference on "Physician Competence: Whose Responsibility?" April 7-9 at the Warwick Hotel in Houston.

This is the fourth in a series of conferences in which the AMA has joined with American Hospital Association and the Association of American Medical Colleges to explore common issues in healthcare.

Topics and invited speakers include:

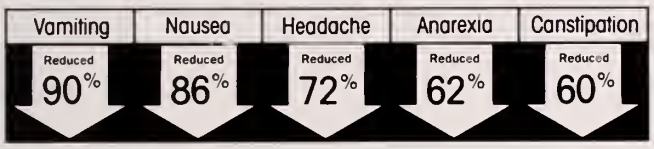
- Role of state government: David Axelrod, MD, Commissioner of Health, New York State Department of Health
- Responsibility of the profession: Philip Lee, MD, Director, Institute for Health Policy Studies, University of California-San Francisco
- Competence assessment during medical school: Joseph Gonnella, MD, Dean and Vice President, Jefferson Medical College of Thomas Jefferson University
- Competence assessment in clinical practice: Dennis O'Leary, MD, President, Joint Commission on Accreditation of Health Care Organizations
- Ethical perspective on competence assessment: Willard Gaylin, MD, The Hastings Center

Those wishing further registration or program information should contact Ira Singer, 312/645-4655. Press coverage of this conference is invited. Reporters should contact Pat Clark at 312/645-4497 for assistance with credentials and interviews.■

See the improvement in the first week[1]

- **Sleep improvement in 74% of patients after first h.s. dose[2]**
- **Significantly faster relief–62% of total four-week improvement evident in first week versus 44% with amitriptyline alone[1]**
- **Dramatic first-week reduction in somatic complaints[2]**

% Reduction in Somatic Symptoms[2]



- **Only ⅓ the dropout rate due to side effects of amitriptyline alone, although the incidence of side effects is similar[1]**

Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

Protect your decision.
Write "Do not substitute."

In moderate depression and anxiety

Limbitrol®

Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) (IV)

Limbitrol® DS

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) (IV)

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References: 1. Feighner JP, *et al Psychopharmacology 61* 217-225, Mar 22, 1979 **2.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ

Limbitrol® (IV)
Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs. Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.
How Supplied: *Double strength (DS) Tablets,* white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets,* blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt). Available in bottles of 100 and 500, Tel-E-Dose® packages of 100. Prescription Paks of 50.

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The rewards of Limbitrol
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Strategic Planning Committee Report . . . Approved by the Board of Directors, and forwarded to the House of Delegates, reviews past and present SMS activities, the opinions of SMS members about the Society and Wisconsin's medical practice environment. The report also details the committee's recommendations on the Society's mission and priorities for the future (see page 41).

New directions . . . Secretary-General Manager Adams looks toward tomorrow in his report to the membership. His main topics are the formation of a Blue Ribbon Task Force on Alternatives to the Tort System and the report of the Strategic Planning Committee (see page 9).

Family health . . . This year's Annual Meeting will focus on the theme of Family Health Concerns for 1988. Several panels have been designed to probe many of the issues affecting and surrounding the health of today's American family (see page 21).

AIDS recommendations . . . The Board of Directors has approved 30 recommendations of the SMS Task Force on AIDS. The recommendations come under six general headings: education, provision of care, funding, testing, confidentiality and public health measures (see page 28).

MARCH 1988

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WISCONSIN MEDICAL JOURNAL (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Society's Board of Directors. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. Unsigned Editorials express views consistent with the policies of the State Medical Society of Wisconsin. Signed Editorials express personal views of the author for which the Society takes no responsibility. Neither the Editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus," "Hospital Literature Index," and "Cambridge Scientific Abstracts."

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THE STATE MEDICAL SOCIETY OF WISCONSIN, created by the Territorial Legislature in 1841, represents over 6700 member physicians in Wisconsin, comprising 55 county medical societies and 28 medical specialty sections. The purpose of the Society is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society include continuing medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, services for physicians, operation of a Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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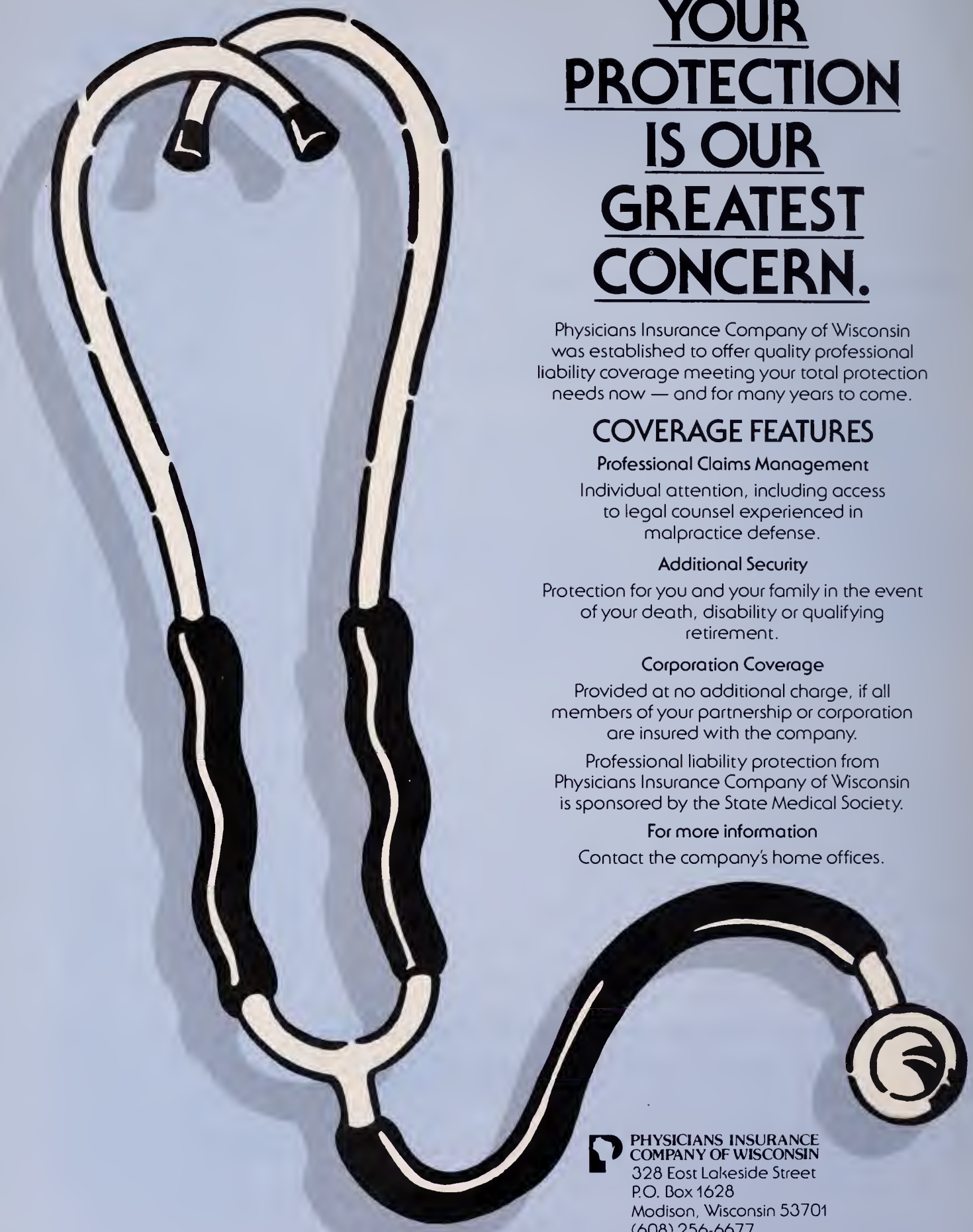

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Runaway reproductive technology

MODERN REPRODUCTIVE technology presents the medical profession with issues of awesome significance. Within our hands are tools that can be used for the greater good of the human race or misused for mankind's degradation.

These issues are analogous to the situation faced by scientists and governments in the creation and manufacture of atomic and hydrogen bombs during the 1940s and 1950s. Was it right for us to create such monstrous weapons? Many scientists had extreme reservations about the wisdom of such a course. Under the pressure of wartime fears that the Nazis would be successful in these endeavors, and thus achieve worldwide domination, our political leaders chose to proceed.

In the 1980s we see the results of these decisions. The world still lives in fear, despite having vast amounts of its wealth diverted to these channels. And since this wealth is sapped from the world's economy, the continuing confrontation of the superpowers impairs the well-being of all its citizens.

In reproductive technology we are faced with similar issues. Which is the path of wisdom? With the success of *in vitro* fertilization, a veritable Pandora's box has been opened. With the opening of the box, will we

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see a further dehumanization of the individual? Will we see embryos and fetuses treated as objects of medical research without regard for their humanity? Will we see the children born through *in vitro* fertilization used for transplantation surgery without regard for their individual rights?

In the struggle for acceptability of surrogate motherhood, very little attention is paid to the rights of the babies to know their biological parents. These babies are treated as pieces of property rather than a gift of a loving relationship between two persons committed to each other. As surrogate babies mature, the psychological impact of their mode of conception will be interesting to observe. The relentless pursuit of adopted children to find their biological parents is too well known to need further elaboration. How much more difficult will it be for surrogate children in the future when they try to establish their identities?

The original agenda proposed by scientists for approval of *in vitro* fertilization came across as a simple, compassionate response to an infertile couple's desire for a child of their own. It is obvious that this initial tampering in the origins of human life has led to surrogate motherhood, embryo implantation, and embryo flushing.

Some scientists are now looking forward to cloning, ectogenesis, hybridization, and genetic breeding. These are weighty issues for society to contemplate. Lost in these issues are the sacredness, the value, and the individual humanity of the embryo. In some instances embryos and fetuses have been treated as objects, rather than as human beings worthy of our concern.

In this country, there has been very little discussion about runaway reproductive technology and its regulation. Surrogate motherhood has caught the attention of the public, and bills have been introduced in nearly 30 states to regulate this pernicious practice. The fundamental issues, however, are much more serious and should be addressed by both the medical community and society at large.

The future of humanity is at stake, for as we have witnessed with the atomic bomb—such genies are very difficult to control once let loose upon the world. The time is late to inaugurate these discussions; but if humanity is to be protected against itself, it is important to begin them now.

Value-free scientists who pursue science for science's sake, without regard for its effect on humanity, will need to be controlled by legislation if they cannot control themselves. Reproductive technology, like war, cannot be left in the hands of so-called experts. Society must exert its strength to control its own destiny according to values which ensure the dignity and sanctity of each of its members.

—John P Mullooly, MD, Milwaukee■

LETTERS

The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

VCRs and children

TO THE EDITOR: Approximately 17 million families in the United States own video cassette recorders (VCR). While widening entertainment choices, these devices may be dangerous to inquisitive children's hands. We recently treated a child who suffered a hand injury while playing with a VCR, and reviewed VCR and tape deck injuries reported to the National Electronic Injury Surveillance System (NEISS).[1]

The infant we treated was an 11-month-old male who placed his hand inside the family VCR. An older sibling, wanting to "see his brother's thumb on TV" pressed the play button on the remote control device. The machine engaged, pulled the patient's hand into the machine, and trapped his thumb. The patient's mother quickly turned off the machine and dislodged his thumb. Physical examination in the emergency department revealed a markedly swollen left thumb with a 1½-centimeter laceration across the thumb pad surrounded by macerated tissue, and a small subungual hematoma. An x-ray film was normal. Sutures were not required, and the thumb was cleaned and dressed.

The NEISS compiles annual statistics of injuries resulting from the use or abuse of electrical equipment. Pediatric injuries from tape decks or VCRs reported to NEISS during the years 1984 and 1985 included: lacerated fingers (9) or other body parts (3), contusions (2), and ingestions of tape deck head cleaner fluid (2). Only the hand injury we reported was caused by a VCR, all other lacerations were caused by eight-track tape decks.

Finger and hand lacerations, the most common types of injuries reported, may be related to the make of tape deck or VCR.

The front loader, which caused the reported injury, has a free-swinging door to the tape compartment. Once the play button is pressed, the tape—or whatever is in the compartment—is engaged. The small swinging door of the front loader or eight-track tape deck can be attractive to a youngster looking for a garage for his cars or hiding place for other small toys. The top-loading style requires a more complex sequence to engage the tape, and may decrease the risk of children engaging the system.

1. US Consumer Product Safety Commission, National Injury Information Clearinghouse Accident Investigations. Electronic Injuries. 1984-1985.

Warnings accompanying most VCRs caution against placing fingers or objects into the unit because of the high voltage inside. If the unit is on and continuously connected to the television (as occurred in our report), the remote control can be used to change TV channels when the unit is not being used for tape viewing. Leaving an empty VCR in this "on" position creates an electrical hazard.

Several simple interventions by parents may prevent future injuries. The VCRs and their cables should be placed out of the reach of small children. Three injuries reported to the NEISS were to small children who tugged at the cables and caused the VCR to tumble down upon them. The power should be off when not in use for tape viewing, and the remote device out of reach of children. Top-loading styles may be safer in homes with small children.

—*Holly M Maes, MD*
Jeffery S Garland, MD
Peter W Glaeser, MD
Department of Pediatrics,
Children's Hospital of Wisconsin,
Medical College of Wisconsin,
Milwaukee.■

SOUNDINGS

Names

David L Schiedermayer, MD
Milwaukee, Wisconsin

SOMETIMES, patients names reflect their diseases. Of course, that may be coincidental, but sometimes I wonder if there may be a self-fulfilling prophecy. For example, John Sleeper came in complaining of continual fatigue, and lack of energy and vigor. August Lake was being evaluated for confusion, and the diagnosis was too much water on the brain —normal pressure hydrocephalus. Thomas Pillsbury complained of stomach upset.

I can tell by the name whether the patient is old—names like Purlene, Gwendolyn, and Thelma are old names. Newer names are Shannon and Jonathan. Timeless names are James, Susan and Mary. There also are some interesting names: Prince Lady, Rosa King, Pinkie, Guadalupe, Roeshell, Vonzed Gundie, Javie, Whisera, Arvie, and M.D.

I am no critic of names. Rather, I feel I must keep track of these names, for to me they are very much a part of what I do. If I can remember a person's name and if I can remember something about him or her, I feel I have gone far in establishing our relationship. For me, knowing the names of the patients, their faces, and something about them besides their diseases, is part of practicing good medicine.■

Doctor Schiedermayer is Assistant Professor, Division of General Internal Medicine, and Associate Director, Center for the Study of Bioethics, Medical College of Wisconsin, Milwaukee. Reprint requests to: David L Schiedermayer, MD, Center for the Study of Bioethics, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, Wis 53226 (phone 414/257-6040). Copyright 1988 by the State Medical Society of Wisconsin. Some of the names in this piece have been somewhat altered to protect patient confidentiality.

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Forward, ever forward

THOMAS L ADAMS
Secretary-General Manager

IN THE JUNE 1987 issue of the *Wisconsin Medical Journal,* I indicated that the Board of Directors had authorized the development of a strategic plan for the Society. I am pleased to report that the Executive Committee has completed that process which has resulted in a draft plan that was subsequently amended and adopted by the Board of Directors in January 1988. The plan will be before the House of Delegates in April.

This issue of the *WMJ* contains a draft copy of that plan. I urge you to read it carefully. It is the document that will provide the framework for the SMS decision-making process for the next three to five years. You should forward your comments or thoughts to your representative in the House of Delegates. As always, that body will make the final determination on acceptance of the plan.

The Executive Committee sought the advice and counsel of many during the developmental stages of the Strategic Plan. A membership survey regarding the use of Society services and perceptions of the effectiveness of the Society was returned by more than 50 percent of our members. Focus groups involving 150 physicians were conducted during the October 1987 leadership conference, and the advisory committee of the Wisconsin Clinic Managers Association provided additional input. The resulting document drafted by the accounting and consulting firm of Coopers and Lybrand in Chicago is, in my opinion, a strong affirmation of ongoing Society activities and a blueprint for future improvements. I would like to express the thanks of the senior staff and myself to the committee for its attendance at an extra six full days of meetings and to Douglas Hough, the Coopers and Lybrand partner who facilitated our efforts.

* * *

The Blue Ribbon Task Force on Alternatives to the Tort System began its work in February. Over the next year and a half, the Task Force will explore such ideas as no-fault malpractice insurance, new administrative, arbitration-based alternatives and others. The Task Force will then make a recommendation(s) for legislative initiatives to the Board of Directors and House of Delegates.

The idea behind this effort was to involve non-physician opinion leaders in the formation of new alternatives. A broad based group of individuals was persuaded to work with the Society on the task force. The Board believes that by their participation, we may be able to form a consensus of opinion leaders that in turn will enhance our ability to achieve legislative change.

Non-physician members of the task force at this time include, John Duncan, president, Metropolitan Milwaukee Association of Commerce; John Parr, executive director, AFCME Council 48; Bob Haase, commissioner of insurance; Gordon Baldwin, professor, University of Wisconsin School of Law and a leading constitutional authority; and Sen David Helbach. Physicians serving include Roger L von Heimburg, MD (surgery), Chair; Richard G Roberts, MD (family practice), John O Simenstad, MD (surgery), Darold A Treffert, MD (psychiatry), C Robert Jackson, MD (obstetrics), and William L Treacy, MD (internal medicine).

I believe that the deliberations of this task force are critical to both the direction and viability of our efforts to change the tort system in Wisconsin. Staff will be working closely with the task force on developing the proposals. You will be kept informed through the vehicles of county medical society meetings and the *WMJ.* New directions are necessary. I am confident that they can be developed and proposed by the task force and SMS.■

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Bilateral Pseudallescheria boydii endophthalmitis in an immunocompromised patient

James G Caya, MD; Silas G Farmer, PhD; George A Williams, MD; Timothy R Franson, MD; Richard A Komorowski, MD; and *Jane C Kies, MD,* Milwaukee, Wisconsin

ABSTRACT. **Pseudallescheria boydii (P. boydii)** ***endophthalmitis is a rarely encountered infection caused by an opportunistic pathogen that typically afflicts patients with predisposing risk factors. We herein describe the first reported case of culture proven, bilateral* P. boydii *endophthalmitis. The organism responsible for this catastrophic infection, occurring in an immunosuppressed renal transplant patient, was resistant to clinically achievable levels of amphotericin B and ketoconazole. Our case emphasizes the need to consider fungal endophthalmitis in the differential diagnosis of intraocular inflammation, especially in the immunocompromised patient.***

Key words: Pseudallescheria endophthalmitis

OPPORTUNISTIC INFECTION in the immunocompromised patient represents an increasingly frequent challenge relevant to the practice of many physicians, including ophthalmologists. We herein report a case of culture proven, bilateral *Pseudallescheria boydii* endophthalmitis occurring in an immunosuppressed renal transplant patient. This case represents the only reported instance of bilateral *P. boydii* endophthalmitis, and serves to emphasize the importance of culture and antibiotic sensitivity studies when treating an ocular fungal infection.

From the Department of Pathology (JGC, SGF, RAK), the Department of Opthalmology (JGC, GAW, JCK) and the Department of Internal Medicine, Infectious Disease Section (TRF), Medical College of Wisconsin, Milwaukee, Wisconsin. Publication support provided. Reprint requests to: James G Caya, MD, Department of Pathology, Medical College of Wisconsin, 8700 W Wisconsin Ave, Milwaukee, WI 53226 (phone: 414-257-6201). Copyright 1988 by the State Medical Society of Wisconsin.

Materials and methods. Fungal studies were performed at the Milwaukee County Medical Complex, Pathology Department, Section of Clinical Microbiology, a tertiary level laboratory facility. Direct examination of vitreous fluid was accomplished by both Papanicolaou and Gram stain preparations. Cultures of this fluid were performed on Sabouraud's dextrose agar at 25°C.

Antibiotic sensitivities were tested by the agar dilution method employing unbuffered yeast nitrogen base agar supplemented with glucose, a modification of the method of Block and Bennett.[1] The minimum inhibitory concentration (MIC) was read as the least concentration which completely inhibited growth.

Eye tissue was fixed in 10% buffered formalin for more than 48 hours and then sectioned at 6-micron intervals. Hematoxylin and eosin (H&E), periodic acid Schiff (PAS) and Gomori's methenamine silver (GMS) stains were performed on these microsections.

Case report. This 49-year-old male was last admitted to our medical center with fluid and electrolyte disturbances related to severe diarrhea and vomiting of uncertain etiology. His medical history included end stage renal disease (secondary to chronic glomerulonephritis), which eventually necessitated a cadaveric renal transplant 1 year prior to admission. He also had a history of miliary tuberculosis and cardiomyopathy, and of receiving immunosuppressive therapy (azathioprine and methylprednisolone) and isoniazid.

The physical examination revealed an oriented but wasted and hypotensive man. Examination of the eyes revealed no abnormalities. The patient improved after appropriate fluid and electrolyte therapy, but then developed *E. coli* septicemia and a pulmonary infiltrate, both of which responded to antibiotics. The patient also developed an intermittent fever of unknown cause.

On his 56th day in the hospital, the patient complained of photophobia and pain in the left eye. His temperature was 39.8°C; bilateral conjunctival chemosis and injection were noted. His best corrected visual acuity was 20/50 on the right, and he could count fingers at 12 inches on the left. Schiotz tension was 6 mm Hg bilaterally. The right media, lens and vitreous were clear. The left media were hazy with anterior chamber fibrin membrane and keratic precipitates, thereby precluding evaluation of fundus detail. During this time, the patient's peripheral white blood cell count and differential were normal and blood cultures were negative. The initial diagnostic impression was anterior uveitis, so cycloplegic therapy and topical steroids were begun.

There was initial symptomatic and clinical improvement, but seven days later, a left hypopyon developed and endogenous endophthalmitis

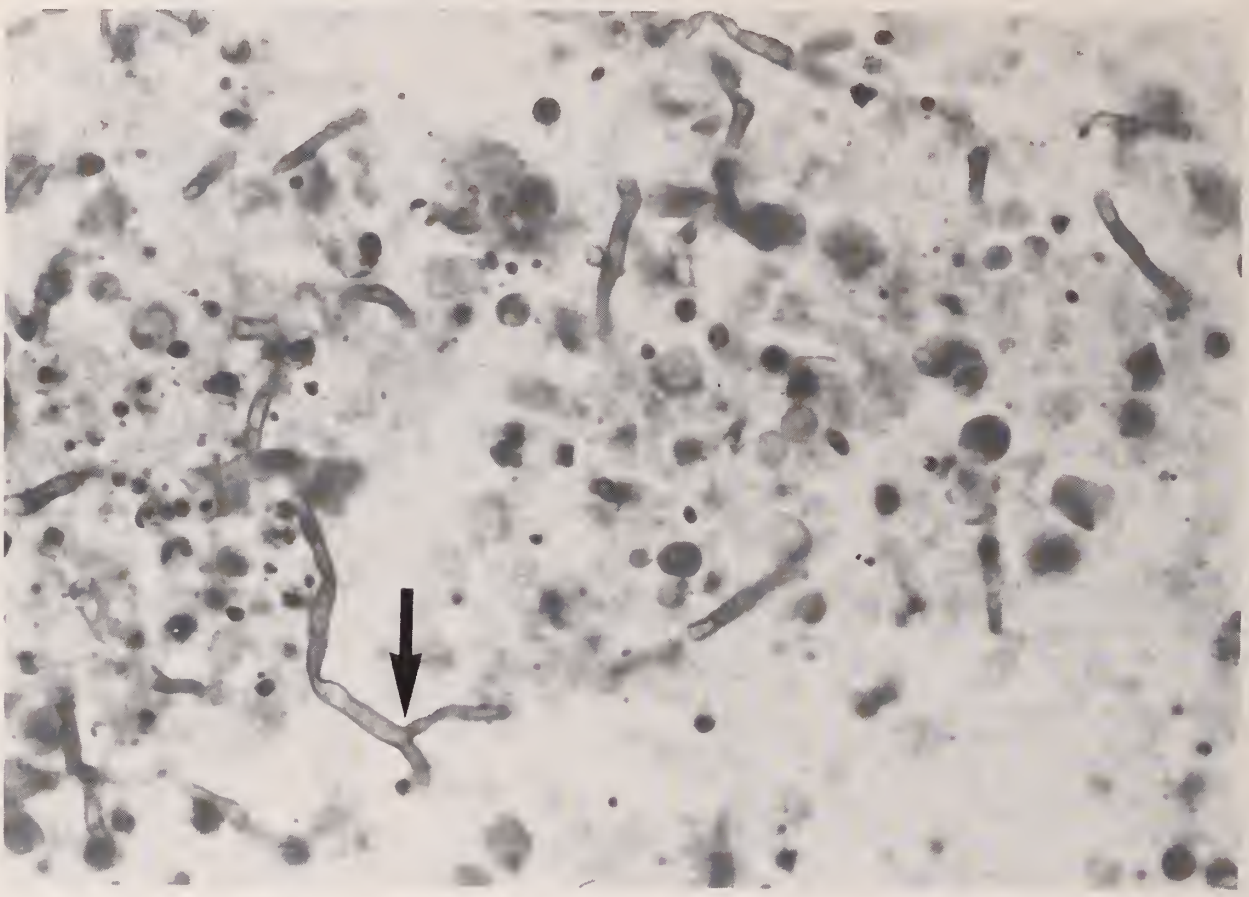

FIGURE 1—*Numerous* **P. boydii** *organisms (arrow) are seen in the vitreous cavity from the enucleated left eye. Necrotic debris and numerous degenerating inflammatory cells are also present (320 x, GMS stain).*

was suspected. The patient became obtunded with severe metabolic disturbances leading to cardiovascular instability that prevented planned vitreous and aqueous aspiration. A lumbar puncture was consistent with bacterial meningitis, but all bacterial and fungal cultures were negative.

Six days later, the patient's medical condition had improved enough to allow diagnostic vitrectomy, under general anesthesia, in the left eye. Examination under anesthesia of the right eye demonstrated new vitreous opacities. A preparation of Papanicolaou-stained, left-eye vitreous fluid showed structures suggesting fungal organisms. Two days after the biopsy, cultures were positive for fungus, and systemic amphotericin B was begun.

Vision declined to perception of hand motion in the right eye and of light only in the left eye over the next 48 hours. Because of dense vitreous organization, a right vitrectomy and bilateral intraocular amphotericin B injections (5 micrograms on each side) were performed. Over the next seven days, vision further declined to light perception only in the right eye and no light perception in the left. Inflammation in both eyes worsened, and severe pain developed in the left eye. Because of the poor clinical response to amphotericin B, the fungus was assumed to be resistant to the drug.

The organism was definitively speciated as *P. boydii,* and systemic miconazole therapy was begun. The left eye was enucleated and sent for cultures. Intravitreal miconazole (25 micrograms) was injected into the right eye. Repeat cultures confirmed *P. boydii* in the vitreous of both eyes.

The patient subsequently developed a cerebritis and underwent neurosurgical drainage of a frontal lobe abscess on the 95th hospital day. Cultures from this abscess grew *P. boydii.* The right eye demonstrated some clinical improvement with clearing of the vitreous, but the patient remained obtunded and subsequently developed septic shock. He died on the 110th hospital day, but his family refused to consent for an autopsy.

Results. Cultures of vitreous fluid from both eyes revealed a fungal organism; colonies were rapid growing, spreading, cottony, at first white and then changing to a pale smoky brown. Cleistothecia formed just below the agar surfaces; asci were globose to subglobose with eight ovoid to ellipsoid, smooth pale yellow-brown to copper ascospores. The predominant form was characterized by hypha-like conidiophores of varying lengths. The organism was identified as *Pseudallescheria boydii* with the predominant asexual anamorph *Scedosporium apiospermum.*

The MICs of various antimicrobial agents were determined. The MICs for miconazole, ketoconazole, and amphotericin B were 0.25, 12.5 and

5.0 micrograms/ml, respectively.

Microsections of the globe demonstrated hypopyon with hemorrhage and necrosis of the anterior segment structures. The lens was focally necrotic, and acutely inflamed necrotic debris filled the vitreous cavity. Enmeshed within this striking inflammatory milieu were numerous PAS- and GMS-positive septate fungal organisms. These organisms had an average width of 7 microns and displayed 45-degree angle branching (Fig 1), but no definitive chlamydospores were seen.

Discussion. *Pseudalleschia boydii* (previously known as *Allescheria boydii, Petriellidium boydii,* and *Monosporium apiospermum*) is a virtually ubiquitous fungus capable of causing a wide spectrum of disease in man, including mycetoma (a suppurative infection usually involving the extremities in apparently otherwise healthy people) and life-threatening visceral infections in predisposed patients.[2,3]

The literature documents at least 14 instances of *P. boydii* keratitis; most of these patients had sustained corneal injury prior to the development of this infectious complication.[3] Similarly, an instance of orbital *P. boydii* infection is reported to have complicated a penetrating traumatic injury.[4] Eyelid and lacrimal gland *P. boydii* infections are also chronicled in the literature.[3] Four reports of *P. boydii* endophthalmitis are contained in the literature.[5,8] None of these are reportedly bilateral in nature. The clinical features of these cases, as well as those from our own case, are summarized in Table 1.

Our case of bilateral *P. boydii* endophthalmitis serves to emphasize several important clinical points concerning the immunocompromised patient. (1) The ophthalmologist must always maintain a high index of suspicion for fungal endophthalmitis in the immunocompromised patient with intraocular inflammation. (2) This heightened awareness for fungal infection should clearly encompass the spectrum of low-grade opportunistic pathogens such as *P. boydii.* (3) The consulting ophthalmologist must be ever vigilant for contralateral endophthalmitis in patients with unilateral fungal endophthalmitis, especially in immunocompro-

Table 1—*Pseudallescheria boydii endophthalmitis—literature review*

Case	Age (Yr) and Sex	Predisposing Factor(s)	Interval from onset of ocular symptoms/signs to definitive diagnosis	Treatment*	Clinical Outcome	Reference
1.	49/F	a) Diabetes mellitus. b) Extracapsular cataract extraction with post-op steroid drops.	22 days	Topical amphotericin B.	Alive and well at 8 months with 20/30 vision (corrected) in affected eye.	5
2.	32/F	a) Lupus erythematosus, on prednisone and azathioprine until 2 weeks prior to onset of ocular complaints. b) Multiple antibiotics for pneumonia. c) Leukopenia.	8 days	a) Vitrectomy with intravitreal amphotericin B. b) IV miconazole. c) Evisceration of affected globe.	Alive and stable at 9 months.	6
3.	15/F	a) Seizure disorder; suffered cardiac arrest and aspirated muddy water. b) Treated with broad spectrum antibiotics and prednisolone for aspiration pneumonia.	12 days	a) IV amphotericin B. b) Vitrectomy. c) IV miconazole.	Died 3 weeks after diagnosis; widespread *P. boydii* infection noted.	7
4.	31/M	a) Congenital aortic stenosis with worsening cardiac failure. b) Aortic valve replacement with porcine graft. c) Aortic graft for repair of aneurysm.	18 days	a) Vitrectomy and intravitreal miconazole. b) IV miconazole.	Died 2 weeks after definitive diagnosis; widespread *P. boydii* at autopsy, including brain and aortic valve prosthesis.	8
5.	49/M	a) Renal transplant patient on methylprednisolone and azathioprine. b) Recent pneumonia treated with broad spectrum antibiotics.	27 days	a) Vitrectomy and intravitreal amphotericin B (OU); also intravitreal miconazole (OD). b) Enucleation (OS).	Died 4 weeks after definitive diagnosis with brain abscess positive for *P. boydii.*	Present case

*IV = Intravenous

mised hosts, because these individuals are profoundly susceptible to blood-borne spread of their infections. (4) All intraocular infections should be thoroughly speciated by means of microbiological studies, including fungal culture. Morphologic evaluation (such as that obtained from smears of intraocular fluids) does *not* replace microbiological culture in definitive speciation of causative organism(s). This point is amply demonstrated by our case, which reinforces the view held by others that *P. boydii* organisms in cytologic and histologic materials may be morphologically indistinguishable from those of *Aspergillus* species.[9] (5) Antibiotic sensitivity evaluation should be performed on all intraocular fungal isolates. These sensitivity data may prove to be of critical clinical importance.[10-13] Indeed, the reported susceptibilities of *P. boydii* isolates to ketoconazole and amphotericin B vary greatly.[14] The range for ketoconazole is from 0.25-12.5 ug/ml; our isolate was 12.5 ug/ml. Achievable tissue levels for ketoconazole are from 0.5 to 6.0 ug/ml.[14] The range of susceptibility to amphotericin B is from 1.56 to >100 ug/ml; our isolate had an MIC of 5.0 ug/ml. It is rare, however, to get tissue concentration of amphotericin B in excess of 4.0 ug/ml.[14] *P. boydii* isolates reportedly vary in susceptibility to miconazole from <.016 to 4.0 ug/ml. Achievable tissue levels vary from 0.3 to 6.0 ug/ml.[14] The susceptibility of the isolate from our patient, 0.25 ug/ml, is well within achievable tissue levels.

Ocular infections caused by *P. boydii* are uncommon, although the frequency of such occurrences would be expected to rise as ophthalmologists are called upon to see an ever increasing number of immunocompromised patients. A high index of suspicion for fungal endophthalmitis, coupled with scrupulous adherence to the performance of complete culture and sensitivity studies, can assist the ophthalmologist in rendering optimal care to these challenging patients.

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Thymic cyst and infant respiratory distress

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ABSTRACT. ***This report describes the computerized tomographic and radiographic diagnosis of a thymic cyst in a newborn infant. This is an extremely unusual case of respiratory distress in this age group.***

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Key words: Thymic cyst; Infant; Computerized tomography

THYMIC CYSTS represent approximately 1% of all mediastinal masses. They rarely appear in newborn infants and are an uncommon cause of respiratory distress. Computerized tomographic (CT) examination readily establishes the diagnosis and evaluates the extent of the lesion. It provides this information in a noninvasive manner, and no additional diagnostic evaluation is necessary.

Case report. A 1-month-old boy was hospitalized for evaluation of a cyanotic episode. The episode occurred while the infant was sleeping, was not associated with feeding, lasted for approximately one minute, and caused the child to require respiratory assistance. There was no history of prior respiratory difficulty, although the child had been a 'noisy breather' since birth. Physical examination revealed a cyanotic infant in moderate respiratory distress. While no palpable neck mass was present, there was fullness in the left

FIGURE 1—Chest x-ray showing superior mediastinal mass, and deviation of trachea and esophagus to right.

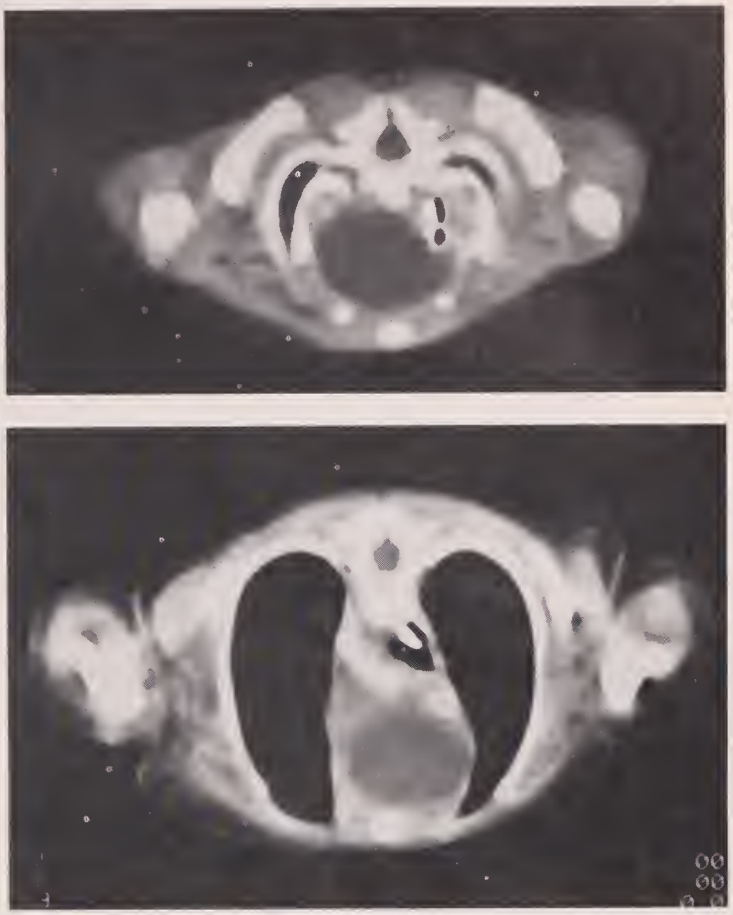

FIGURE 2 A, B—Low attenuation mediastinal mass, with deviation of trachea and esophagus to right.

side of the neck. All laboratory data were normal.

A chest x-ray (Fig 1) showed fullness on the left side of the neck with a superior mediastinal widening. A CT scan of the chest and neck with intravenous contrast material (Figs 2A & 2B) showed a homogeneous, fluid-density mass in the mediastinum and neck, with a deviation of the trachea and esophagus to the right. No associated calcifications were noted. The lesion was totally excised and found to be a benign thymic cyst with chronic fibrosis. During the three months of postoperative follow-up, there was no further respiratory difficulty and no evidence of recurrence.

Discussion. Thymic cysts are uncommon, accounting for approximately 1% of mediastinal masses in all age groups,[1] but are more common in children and young adults. They develop along the embryologic migratory path of the thymus.[2]

Thymic cysts are divided into three major categories: congenital, neoplastic, and inflammatory.[2] They may appear in patients treated for Hodgkin's disease. These patients often have a mediastinal mass at the time of diagnosis. The chest x-ray films return to normal after therapy. Follow-up x-ray films show a new mediastinal mass, suggesting a recurrent disease. The CT scan demonstrates the cystic appearance of the mass. The inflammatory cysts (Dubois) are very rare and are associated with congenital syphilis.[3] The congenital form is thought to arise from either degeneration of Hassall's bodies or persistence of the thymopharyngeal ducts, which become fluid-filled.[1,6]

Most thymic cysts appear as asymptomatic masses. Only 6% have symptoms of mechanical obstruction.[3] If palpable, the mass will often increase in size with crying, secondary either to vascular engorgement or transmission of intrathoracic pressure.[3]

In x-ray films, thymic cysts appear as smoothly contoured anterior mediastinal masses, anywhere from the diaphragm to the thoracic inlet. Other lesions with a similar radiographic appearance include cystic teratomas, lymphatic cysts, cystic lymphoma, and bronchogenic cysts.[6] Thymic cysts are most often near the base of the heart and proximal great vessels. The cysts usually do not calcify; but if they do, there will be a linear calcification of the cyst wall. On a CT scan, they appear as anterior mediastinal masses with attenuation numbers near that of water, and they show no enhancement with intravenous contrast material. CT scans demonstrate the relationship of the cyst to the surrounding structures, septations, as well as any

hemorrhage or infection. When ultrasound is used, these lesions will have the typical characteristics of a cyst. The exception is the infected or hemorrhagic cyst, which has increased internal echoes. Septations are easily identified. Of the different imaging modalities, a CT scan is the most effective: It best characterizes the mass, its extent, and the surrounding structures.

Treatment is surgical excision. There are reports of therapeutic aspirations, but these provide no tissue to exclude tumor. A recent review of 46 patients with cystic lesions of the thymus found four of the lesions to be malignant.[1] There are no reports of recurrence.

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CLINICAL CANCER: Number 22 of a series

Radiation therapy: common questions and answers

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THERE IS A misconception among referring physicians that the practice of radiotherapy is little more than precise delivery of x-rays aimed at a patient's cancer. Today's radiation oncologist, however—with three or more years of specialized training in the staging and natural history of cancer, in the radiobiology of neoplastic and normal tissues, and in the physics of radiation therapy—should be considered an important partner in the clinical studies and staging of each patient.

The radiation oncologist is in a unique position to weigh the potential risks and benefits of curative v palliative treatment plans, to discuss these simply and frankly with the patient; and, taking the patient's wishes into consideration, to select the optimal treatment plan, often with the aid of physicists and dosimetrists. For example, with the aid of computers several different treatment plans can be drawn within an hour based on different types of x-ray or electron beams, different doses of each, variations in the angle of the wedge compensator, etc (Figures 1A and 1B), and then the best plan chosen based on the best fit of the tumor within the prescribed dose.

Figure 1A shows how electrons and x-rays can be combined to treat the internal mammary nodes, chest wall, and axilla without delivering dangerous doses to the underlying heart and lung, while Figure 1B shows how wedge-shaped blocks of lead can be used to compensate for the eccentric location of a tumor near a sloping body surface. These plans are composed of cross-sectional computerized tomographic (CT) images onto which are drawn lines connecting points which will receive the same percentage of the maximum dose, called isodose curves.

Patients usually want to complete their therapy as quickly as possible, and they ask why it takes so long to deliver a course of radiation therapy. The duration actually depends upon the therapeutic goal, and it can vary from a single treatment (to inhibit normal tissue proliferation) to three months or more (for total nodal irradiation).

Radiotherapy for the palliation of bone metastases can be delivered safely in two to three weeks, with a 70% chance of lasting pain reduction. Palliation of other symptoms, such as those that arise from metastatic lymph nodes impinging on nerves or vessels, may take four to five weeks, with a slightly lower likelihood of success. Postoperative radiotherapy (aimed at sterilizing the microscopic spread of cells into the tumor bed after gross resection) will often require five to six weeks. However, radiotherapy delivered with an intent to destroy unresected carcinomas or sarcomas may take up to eight weeks or more. This is because the high radiation doses required

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Physicians are encouraged to contact the authors if they wish to discuss these topics further or obtain additional information. Comments or suggestions for topics would be welcome.

would seriously damage surrounding normal tissues if the same dose were delivered over a shorter time span. Ever since the classic experiments of Claude Regaud in 1920, it has been recognized that cancericidal doses of ionizing radiation have to be divided into fractions that are given several times per week over several weeks. Over the years, a considerable amount of clinical data have been gathered, and these were summarized first by Strandquist and later by Cohen (Fig 2) in a series of isoeffect curves. On a log-log scale, these curves become more or less linear, showing that if a dose of radiation is divided and delivered over a period of days or weeks, a larger total dose must be given to have the same biological effect. Note that the isoeffect curves for the two levels of skin damage, erythema and desquamation (tolerance) are parallel, whereas the slope for the permanent destruction of squamous cell carcinoma is shallower, and the higher values of the latter curve only approach those of the skin tolerance curve after seven or eight weeks.

Many physicians ask about side-effects from x-rays, which vary, of course, depending upon the type and volume of normal tissues irradiated. A complete answer to this question would be enormously complex. Even if we overlook the physics, chemistry, and biology at the cellular level, we must consider acute *v* late effects and whole-body *v* limited-field (tissue-specific) effects.

Acute effects appear within a range of a few minutes to a few months, depending upon the dose of radiation. In the case of whole-body irradiation, doses used to ablate the bone marrow prior to transplantation might also affect the central nervous system (nausea) and the gastrointestinal tract (abdominal cramps and diarrhea). In contrast, very small doses (10 to 15 rads, twice a week for several weeks) for the palliation of advanced non-Hodgkin's lymphomas affect only the hematopoietic system acutely. When more limited fields are used, acute effects are similar to those of classic inflammation (erythema, edema, minute hemorrhages, and tenderness), especially in the tissues that are most sensitive to radiation (hepatic, renal, and pulmonary). Acute effects may persist for days, weeks, or even months.

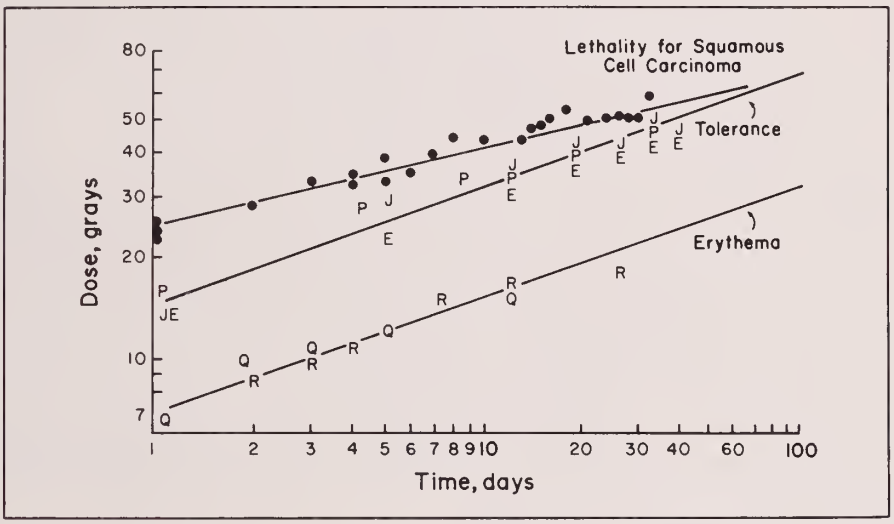
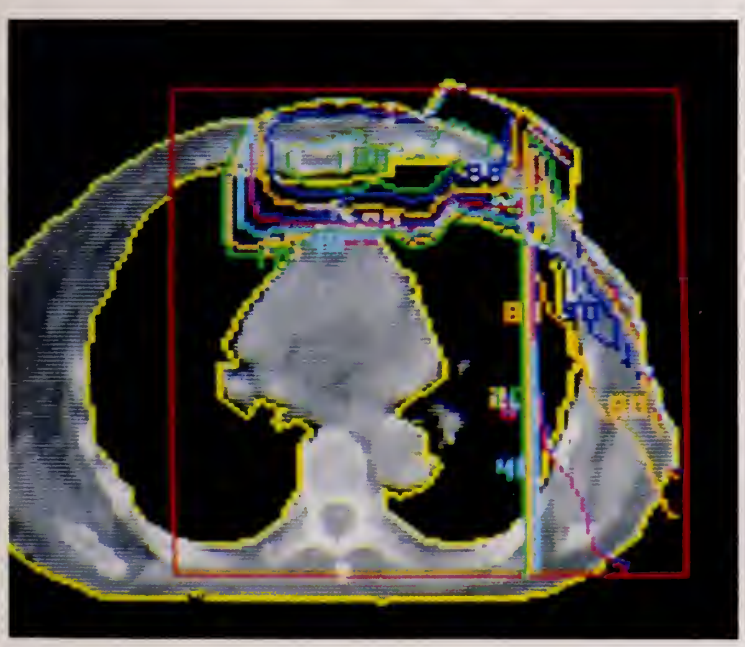
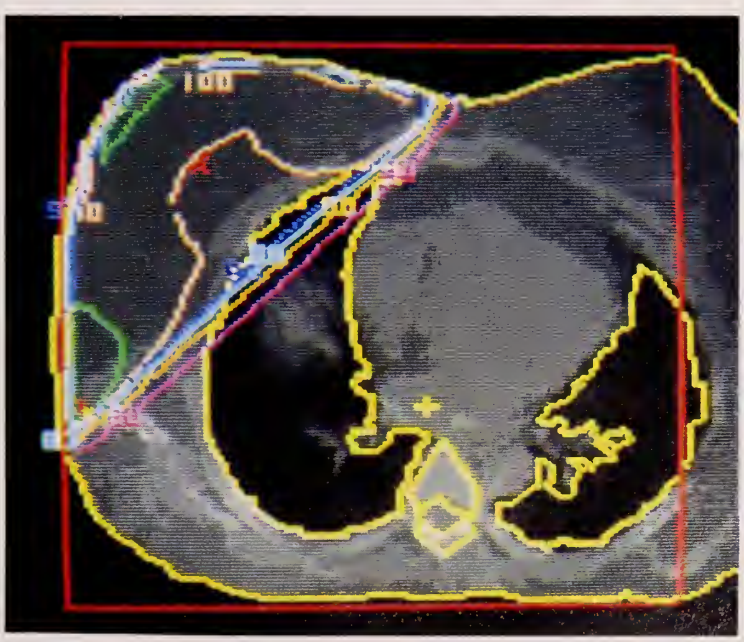


FIGURE 2—*Isoeffect curves relating total dose to the overall treatment time for skin erythema, skin tolerance, and for the cure of squamous cell carcinoma (from Cohen L: PhD thesis,* Radiation Parameters, *University of Witwatersrand, 1960).*





FIGURES 1A, B—*With the aid of computers, several different treatment plans can be drawn.*

Usually they are apparent near the termination of the course of radiation, and they often subside gradually over a week or two.

Late effects may not become noticeable for several months, or even years. As the acute inflammation slowly subsides, some or all of the parenchymal or functioning cells in the irradiated volume will be gradually replaced by diffuse scar tissue. In sensitive and vital organs such as lung or liver the irradiated volumes are usually too small to produce symptoms, but the borders of prior radiation portals are often detected in chest x-ray films or liver scans as areas of increased density or decreased uptake, respectively. Sensitive nonvital organs such as the lens or testis are also shielded if it is feasible to do so without shielding the cancer. However, these tissues are so radiosensitive that scattered radiation will occasionally lead to the development of cataracts or azoospermia, respectively. Other organs are not as radiosensitive. For example, the breast may be relatively safely irradiated in its entirety following surgical excision of an early breast cancer. In this case, late effects translate to the inability of the irradiated breast to produce milk in the rare patient who develops breast cancer at a childbearing age, and slight lessening of the normal breast softness as some of the lipid-containing cells are replaced by fibrous tissue. In the area given extra radiation around the tumorectomy site, small lumps of fat necrosis and telangiectasia in the overlying skin may develop after two to four years.

The incidence of side-effects is obviously related to the dose of radiation as well as to the size and location of the treatment field and the time course over which the dose is delivered. Patients treated with curative intent are more likely to experience both acute and late effects because normal structures near tumor cells often receive doses of radiation that approach tolerance levels for those tissues. A properly informed patient often is willing to accept these side-effects to avoid more radical surgical options (*eg,* mastectomy or laryngectomy for early neoplasms), or to diminish the likelihood of tumor recurrence following surgery for a locally advanced lesion. In contrast, patients treated for the palliation of distressing symptoms usually do not require doses of radiation high enough to cause more than mild side-effects acutely, and late side-effects are not usually of concern in these situations.

Summary. The practice of radiation oncology has been favorably influenced by two changes over the past decade: more rigorous training requirements in oncology and physics, and the availability of far more sophisticated equipment that allows better tailoring of the treatment plan to the individual patient. With increasing assistance from medical physicists, dosimetrists, and other paramedical personnel, the quality of patient care has improved significantly, allowing higher doses of radiation to be delivered more safely. The prospects for continuing improvements in this field are excellent.

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ABSTRACT

Uptake of iodine-131 by a Meckel's diverticulum mimicking metastatic thyroid cancer

Robert H Caplan, MD; Gunnar A Gundersen, MD; R Mario Abellera, MD; and ***William A Kisken, MD,*** Departments of Internal Medicine, Radiology, Pathology, and Surgery, Gundersen Clinic, Ltd, and La Crosse Lutheran Hospital, La Crosse, *Clin Nuc Med* 1987 (Sept); 12(9):760-762.

A 13-year-old girl demonstrated abnormal I-131 uptake in the abdomen after total thyroidectomy for recurrent papillary-follicular thyroid carcinoma. Although a vertebral metastasis was suspected, a negative bone scan and normal computed tomography of the vertebra militated against this diagnosis. A Tc-99m abdominal scintigram and a small bowel roentgenogram revealed images typical of a Meckel's diverticulum. Exploratory laparotomy did not reveal metastases, and I-131 uptake was no longer demonstrated after operative removal of the Meckel's diverticulum. Uptake of I-131 by a Meckel's diverticulum can mimic metastatic thyroid cancer.■

Technological advances in pathology

Biosensors, a fast-developing class of medical devices, hold promise for vastly improving the analytical capability of clinical laboratories, plus allowing simple, rapid, cost-effective bedside monitoring of key biochemical indicators in hospital patients, a report in the July 1987 issue of *Archives of Pathology and Laboratory Medicine* says. The report by Kenneth W. Hunter Jr, ScD, president of Biotronic Systems Corp, Rockville, Md, is one in a series in the *Archives* detailing technical advances important to pathology. Biosensors are tiny electronic devices that use a biological molecule (antibody, enzyme, receptor) as a sensing element for such biochemical parameters as blood gases, hormones, sugars, and other metabolites. Such devices have the potential to vastly improve analysis of complex biological samples in the lab and eventually allow continuous, nearly instantaneous biochemical monitoring of patients via implantable or noninvasive sensor systems, Hunter says.—***AMA Brief Reports***

Before prescribing, see complete prescribing information in SK&F LAB CO. literature or PDR. The following is a brief summary.

Contraindications: There are no known contraindications to the use of 'Tagamet'.

Precautions: While a weak antiandrogenic effect has been demonstrated in animals, 'Tagamet' has been shown to have no effect on spermatogenesis, sperm count, motility, morphology or in vitro fertilizing capacity in humans.

In a 24-month toxicity study in rats at dose levels approximately 9 to 56 times the recommended human dose, benign Leydig cell tumors were seen. These were common in both the treated and control groups, and the incidence became significantly higher only in the aged rats receiving 'Tagamet'.

Rare instances of cardiac arrhythmias and hypotension have been reported following the rapid administration of 'Tagamet' HCl (brand of cimetidine hydrochloride) injection by intravenous bolus.

Symptomatic response to 'Tagamet' therapy does not preclude the presence of a gastric malignancy. There have been rare reports of transient healing of gastric ulcers despite subsequently documented malignancy.

Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chlordiazepoxide, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.), demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. (Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.)

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

Adverse Reactions: Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states (e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation), predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving 'Tagamet', particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in 'Tagamet'-treated patients (approximately 1 per 100,000 patients), including agranulocytosis (approximately 3 per million patients), have been reported, including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia (approximately 3 per million patients) and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly unlikely. A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving 'Tagamet' has been reported.

How Supplied: Tablets: 200 mg. tablets in bottles of 100; 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only); 400 mg. tablets in bottles of 60 and Single Unit Packages of 100 (intended for institutional use only), and 800 mg. Tiltab® tablets in bottles of 30 and Single Unit Packages of 100 (intended for institutional use only).

Liquid: 300 mg./5 ml., in 8 fl. oz. (237 ml.) amber glass bottles and in single-dose units (300 mg./5 ml.), in packages of 10 (intended for institutional use only).

Injection:
Vials: 300 mg./2 ml. in single-dose vials, in packages of 10 and 30, and in 8 ml. multiple-dose vials, in packages of 10 and 25.

Prefilled Syringes: 300 mg./2 ml. in single-dose prefilled disposable syringes.

Plastic Containers: 300 mg. in 50 ml. of 0.9% Sodium Chloride in single-dose plastic containers, in packages of 4 units. No preservative has been added.

ADD-Vantage®* Vials: 300 mg./2 ml. in single-dose ADD-Vantage® Vials, in packages of 25.

Exposure of the premixed product to excessive heat should be avoided. It is recommended the product be stored at controlled room temperature. Brief exposure up to 40°C does not adversely affect the premixed product.

'Tagamet' HCl (brand of cimetidine hydrochloride) injection premixed in single-dose plastic containers is manufactured for SK&F Lab Co. by Travenol Laboratories, Inc., Deerfield, IL 60015.

* ADD-Vantage® is a trademark of Abbott Laboratories.

BRS-TG:L73B Date of issuance Apr. 1987

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In peptic ulcer:

RELIEF
REASSURANCE
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Tagamet®
brand of cimetidine
First to Heal

You'll both feel good about it.

RESULTS

TODAY.

Tax laws have changed this year. And tax forms are different.
So it's smarter than ever to file now and file accurately. If you need help,
call or visit your local IRS office. And make your taxes less taxing.

Make your taxes less taxing. Do them today.

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Family health is focus of Annual Meeting

This year's Annual Meeting program, set for April 28-30 in Milwaukee, will center on the theme of Family Health Concerns for 1988. Several panels have been designed to probe many of the issues affecting and surrounding the health of today's American family.

The panel on sexually transmitted infectious disease will provide current information and guidelines relating to the management of infections with chlamydia and herpes, as well as a review of the guidelines for the prevention of AIDS transmission to healthcare workers in the hospital, office, nursing home and Hospice. This discussion will be held Friday, April 29, from 8:40 am to 11:40 am.

The panel on primary care and office orthopaedics will give an overview of pediatric orthopaedic conditions encountered in the office or on the sports field, the early recognition and management of hand trauma, the non-operative management of common foot problems and a review of the indications for and results of joint replacement. Attendees will obtain a clear idea of the risks and hazards, the indications for referral and the expected outcomes of treatment of these conditions. The panel discussions will be held Friday, April 29, from 1:45 pm to 4:30 pm.

The panel on endocrine glands will explore the current status of management of several conditions which may be poorly understood and for which the recommended management is still in a state of flux. This panel is scheduled for Saturday, April 30, from 9 am to 11:45 am.

Continuing medical education credits are available for all of the panels, which will be held in the Milwaukee Exposition and Convention Center and Arena (MECCA).■

Impaired Physician
Persons interested in the Impaired Physician Program may call 608/257-6781 or toll-free in Wisconsin: 1-800-362-9080 and explain their concern to John LaBissoniere, Sally Wencel, or H B Maroney of the State Medical Society staff. The caller's identity will be kept in complete confidence.

Contemporary jazz musicians, NEO, will perform during the Presidents' Dinner at the SMS Annual Meeting.

NEO to play Presidents' Dinner

Called the "new spirit in American jazz," NEO combines original and interpretive jazz into a style all their own. The group's unique blend of acoustic and electric instruments, synthesizers, percussion and vocals creates an original sound that has music critics handing out rave reviews.

This versatile group recently had one of its songs chosen by the Wisconsin Board of Tourism to be used in a statewide video promoting Wisconsin. Its first album, *North Coast,* has been steadily gaining in popularity.

On stage, NEO's world-class musicians fuse creative energies and generate music that is lyrical and passionate, humorous and warm, challenging to the mind and wonderfully entertaining.

NEO will perform at the Annual Meeting, 7 pm Thursday, April 28, during the Presidents' Reception and Dinner.■

Plan now to attend!

1988 ANNUAL MEETING

The State Medical Society of Wisconsin

"Family Health Concerns"

House of Delegates April 28–29
Scientific Programs April 28–29–30

Milwaukee Exposition & Convention Center & Arena (MECCA)
500 West Kilbourn Avenue
Milwaukee, WI 53203
414/271-4000

HEADQUARTERS HOTEL
Hyatt-Regency Milwaukee
333 West Kilbourn Avenue
Milwaukee, WI 53203
414/276-1234

Presented by the SMS Scientific Program Committee:
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Charles E Holmburg, MD, Madison, Co-Chairman
George Nemec Jr, MD, Woodruff, Co-Chairman
and the Commission on Continuing Medical Education

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Lee Richardson, MD, Green Bay
William M Toyoma, MD, Marshfield
Thomas L Zurbriggen, MD, La Crosse
Ed Zupanc, MD, Monroe
Dianne L Zwicke, MD, Milwaukee

PRESIDENTS' RECEPTION AND DINNER • THURSDAY, APRIL 28, 1988

State Medical Society of Wisconsin President Kenneth M Viste Jr, MD and Auxiliary President Barbara Newcomer invite members to spend the evening enjoying the innovative five-piece jazz band called NEO following the Annual Meeting dinner at the Regency Room, second level of the Hyatt-Regency, Milwaukee. Reception starts at 7:00 pm followed by the dinner at 8:00 pm.■

SUMMARY OF EVENTS: 1988 Annual Meeting, Thursday-Friday-Saturday, April 28-29-30

Thursday, April 28

7:00 am
District I Caucus

7:00 am–8:00 am
District II Caucus

7:30 am–4:00 pm
Auxiliary Registration
House of Delegates

8:00 am
SMS Section Delegates Caucus

8:00 am–9:00 am
Young Physicians Section Caucus Breakfast Meeting

8:00 am
Registration
House of Delegates

9:00 am
First Session
House of Delegates

9:00 am
Auxiliary House of Delegates

11:30 am
Committee on Alcoholism and other Drug Abuse and Auxiliary luncheon program

11:45 am
Charitable, Educational, Scientific luncheon

12:00 pm–1:00 pm
Reference Committee Luncheon

1:00 pm
Reference committees

1:30 pm–4:00 pm
Committee on Aging and Extended Care Facility

2:00 pm
Auxiliary House of Delegates

4:00 pm–5:30 pm
Auxiliary New Board Orientation

4:00 pm–5:30 pm
Auxiliary Pin and Gavel Club

4:00 pm–5:30 pm
Commission on Continuing Medical Education–Directors of Medical Education meeting/reception

7:00 pm
Presidents' reception

8:00 pm
Presidents' dinner

Friday, April 29

7:00 am
Medicine and Religion breakfast

8:00 am–9:00 am
Young Physicians Section Caucus Breakfast Meeting

8:40 am–11:40 am
Preventive Medicine Program

8:40 am–11:40 am
Sexually Transmitted Infectious Disease (panel)

9:00 am–3:30 pm
Emergency Medicine and American College of Physicians program

9:00 am
District I Caucus

9:00 am–10:00 am
District II Caucus

9:00 am
Auxiliary House of Delegates

9:00 am–11:30 am
Family Medicine Program

Medical Liability Committee program

10:00 am–11:30 am
Wisconsin Nursing Association Liaison Committee program

11:30 am
Auxiliary Inaugural luncheon

11:45 am
Socioeconomic/WisPac luncheon/program

1:00 pm
House of Delegates registration

1:00 pm–5:00 pm
Plastic Surgery program

1:30 pm–5:00 pm
Psychiatry and Mental Health Committee program

1:45 pm–5:00 pm
Second and Third Sessions, House of Delegates

1:45 pm–4:15 pm
Primary Care and Office Orthopaedics (panel)

4:30 pm–5:30 pm
Joint Annual Meeting with Wisconsin Society of Preventive Medicine and Preventive Medicine Section

6:00 pm
Past Presidents; reception and dinner

6:30 pm
Wisconsin Society of Internal Medicine dinner

6:30 pm
Wisconsin Society of Plastic Surgeons dinner

6:30 pm–9:15 pm
Women Physicians & Women in Medicine dinner/program

Saturday, April 30

7:30 am–9:00 am
AMA Breakfast

7:30 am–1:00 pm
Otolaryngology program

8:00 am
SMS Board of Directors breakfast meeting

8:30 am–12:30 pm
Anesthesiology program

9:00 am–11:45 am
Internal Medicine and American College of Physicians program

9:00 am–4:00 pm
Pathology program

9:00 am–11:45 am
Endocrine (panel)

10:00 am–12:00 noon
Radiation Oncology program

12:15 pm–4:00 pm
Allergy and Clinical Immunology program

12:30 pm–3:00 pm
Wisconsin Society of Internal Medicine Council luncheon meeting

1:00 pm–4:30 pm
Dermatology program

1:15 pm–4:30 pm
Physical Medicine and Rehabilitation program

1:30 pm–5:00 pm
Surgery program

6:00 pm–7:00 pm
Wisconsin Surgical Society dinner.■

District caucus meetings

Caucus meetings have been scheduled in SMS districts during the next few months to review resolutions and conduct other business relating to the 1988 Annual Meeting of the State Medical Society April 28–30, 1988 in Milwaukee. SMS delegates, alternate delegates, state and county medical society officers, AMA delegates and alternates, and any interested members are invited to attend their caucus scheduled below:

District 1—March 22 at 7:30 pm, Marriott Hotel, Brookfield
District 2—March 27 at 2 pm, SMS offices, Madison
District 3—April 18 at 5 pm, cocktails at 6:30, dinner at 7, district meeting following, Stoddard Restaurant, La Crosse
District 4—March 24, cocktails at 6:30 pm, dinner at 7, caucus following, Wausau Club, Wausau
District 5—March 23, cocktails at 6:30 pm, dinner at 7, caucus following, Robbins Restaurant, Oshkosh
District 6—March 30, cocktails at 6:30 pm, dinner at 7, caucus following, Brogan's Restaurant, Green Bay
District 7—April 14, cocktails at 6:30 pm, dinner at 7, caucus following, Lehman's Supper Club, Rice Lake
District 8—April 13, cocktails at 6:30 pm, dinner at 7, caucus following, Quality Inn, Superior

Delegates, alternates, and officers who received reservation cards are asked to complete and return them as soon as possible. For more information, please contact Jackie Millar at SMS offices, 1-800-362-9080 or 608-257-6781.■

PartnerCare growth continues

A voluntary Medicare assignment program

PartnerCare is operational in 30 counties as of March 1, while initial physician sign-up is complete in another 30 counties, bringing to 60 the current number of counties in which physician solicitation for the program is complete (see map). Other counties are joining the fold on a weekly basis, as the drive toward statewide implementation continues. At present, it appears that initial physician sign-up will be complete by April, although not all counties will be ready to begin enrollment at that time.

"We have taken a giant step since last year to boost access to medical care for our state's low-income seniors. PartnerCare's success will increase as elderly learn of this new program, and avail themselves of this opportunity," said SMS President Kenneth M Viste, Jr, MD, Oshkosh.

Doctor Viste will report on "a year in the life" of PartnerCare in his address at the Annual Meeting in April. Physician rallying of support for the program in 1987–88 will be commended further at that time.■

PartnerCare county and physician sign-up

The World's Most Popular K*

Slow-K®

potassium chloride
slow-release tablets
8 mEq (600 mg)

It means "dependability" in almost any language

*Based on worldwide sales data on file, CIBA Pharmaceutical Company.

Capsule or tablet slow-release potassium chloride preparations should be reserved for patients who cannot tolerate, refuse to take, or have compliance problems with liquid or effervescent potassium preparations because of reports of intestinal and gastric ulceration and bleeding with slow-release KCl preparations.

Before prescribing, please consult Brief Prescribing Information on next page.

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The World's Most Popular K

For good reasons

- ☐ **It works**—a 12-year record of efficacy[1]
- ☐ **It's safe**—unsurpassed by any other KCl tablet or capsule[2]*
- ☐ **It's acceptable vs liquids**—greater palatability, fewer GI complaints, lower incidence of nausea[2]
- ☐ **It's comparable to 10 mEq**—in low-dosage supplementation[3†]
- ☐ **It's economical**—less expensive than all other leading KCl slow-release supplements on a per tablet cost to the patient[1]

Slow-K®
potassium chloride
slow-release tablets 8 mEq (600 mg)

For patients who can't or won't tolerate liquid KCl.

*The most common adverse reactions to potassium salts are gastrointestinal side effects.

†Pooled mean serum potassium following oral administration of 30 mEq K-Tab compared to 24 mEq Slow-K in diuretic-treated hypertensives (n = 20) over 8 weeks.

C I B A

References: 1. Data on file, CIBA Pharmaceutical Company **2.** Skoutakis VA, Acchiardo SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride: Bioavailability and safety. *Pharmacotherapy* 1980;4(6):392-397. **3.** Skoutakis VA, Carter CA, Acchiardo SR: Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics. *Drug Intell Clin Pharm* 1987;21:436-440.

Slow-K®
potassium chloride USP
Slow-Release Tablets
8 mEq (600 mg)

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE INSERT)

INDICATIONS AND USAGE
BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.
1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.
2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function, potassium-losing nephropathy, and certain diarrheal states.
3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS
Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS
Hyperkalemia (See OVERDOSAGE).
In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics
Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions
Potassium chloride tablets have produced stenotic and or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis
Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS
General:
The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients
Physicians should consider reminding the patient of the following:
To take each dose without crushing, chewing, or sucking the tablets.
To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.
To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.
To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests
Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions
Potassium-sparing diuretics: see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility
Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C
Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers
The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use
Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS), other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE
The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics, (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSAGE AND ADMINISTRATION
The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

HOW SUPPLIED
Tablets—600 mg of potassium chloride (equivalent to 8 mEq) round, buff colored, sugar-coated (imprinted Slow-K).

Bottles of 100	NDC 0083-0165-30
Bottles of 1000	NDC 0083-0165-40
Consumer Pack—One Unit	
12 Bottles—100 tablets each	NDC 0083-0165-65
Accu-Pak® Unit Dose (Blister pack)	
Box of 100 (strips of 10)	NDC 0083-0165-32

Do not store above 86°F (30°C). Protect from moisture. Protect from light.

Dispense in tight, light-resistant container (USP).

Dist. by:
CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

C87-31 (Rev 8/87)

C I B A

128-3568-A

Medicare changes for RAPs

On December 21, 1987 Congress agreed upon several changes to the Federal Medicare program. Included in these changes were provisions which modified radiology, anesthesiology and pathology services. Some of the changes will be implemented as of April 1, 1988. Major reimbursement changes will occur by January 1, 1989 for radiology and anesthesia services.

These provisions also prohibit any other provision to be construed as authorizing or requiring prospective payment for inpatient RAP services. In other words, there will be no further study of RAP DRGs unless HCFA is specifically instructed to do so by law.

Anesthesia services reductions. The number of base units will be reduced for the medical direction of two or more CRNAs for services provided beginning April 1, 1988. The units will be reduced by:

10% for two concurrent procedures,
25% for three concurrent procedures,
40% for four concurrent procedures.

We are waiting further clarification from HCFA on the definition of concurrent procedures.

For two or more concurrent cataract or iridectomy procedures, the recognized base units will be reduced by 10%.

When submitting claims to WPS-Medicare, it will be required as of April 1 to indicate the number and types of concurrent procedures, along with the names of the CRNAs that are being supervised.

In addition to these changes, Congress has instructed the General Accounting Office (GAO) to conduct two studies on payments to anesthesiologists for supervision of CRNAs. The first study will try to determine if payments to anesthesiologists for CRNA supervision are excessive compared to physician service reimbursement. This study will also examine the use of modifier units by physicians and carriers. The second study will examine the impact of these payment reductions on the use of CRNAs.

A relative value scale (RVS) will be developed for anesthesiology services and should be implemented by January 1, 1989. This will be developed by HCFA in consultation with anesthesia providers and will be put into effect by regulation. This RVS will be developed so that it will not increase HCFA expenditures.

There were no MAAC changes to anesthesia services this year. HCFA sources suggest, however, that further MAAC limitations may be applied to these services in the future.

Radiology services. Medicare payment for radiologist services will be the lesser of a) 80% of the actual charge for the service, or b) a radiology fee schedule to be developed for this provision. Radiology services are defined as services performed by or under the direction of a physician who is certified or eligible to be certified by the American Board of Radiology. Also included are services performed by a physician for whom radiologic services account for at

AIDS Conference scheduled

SMS will be a major sponsor of an AIDS information and education conference scheduled for April 8, 1988 in Milwaukee. The conference, to be held at the MECCA, is titled On the Cutting Edge—the Latest Developments in HIV/AIDS, and is designed for physicians and other healthcare professionals who want the latest information on HIV and AIDS treatment, research, and public policy.

Keynote speakers include Donald P Francis, MD, DSc; Michael S Ascher, MD, FACP; and Jean Pierre Allain, MD. Doctor Francis was formerly director of the Centers for Disease Control's AIDS Laboratory when it first began its work in the early 1980s. Doctor Francis is now the CDC coordinator for the State of California and is an internationally renowned expert in AIDS and HIV infection. Likewise, Doctor Ascher has done substantial research on HIV transmission and testing, while Doctor Allain's work has been in the area of medical research. Doctor Allain currently serves as manager of medical research for Abbott Labs, Abbott Park, Ill.

Program topics include epidemiology of AIDS and the history of the AIDS epidemic, public policy and prevention issues, biological transmission of the disease, testing accuracy and new tests, and the latest in medical research.

In addition, the conference will offer presentations and workshops on treatment of AIDS patients, current Wisconsin law, and a Wisconsin epidemiology update. SMS members should watch their mail for a complete conference brochure and registration materials. The registration fee is $25 per participant. For further information, contact SMS Communications Division, 800-362-9080 or 608-257-6781.■

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CLASSICAL ITALIAN RESTAURANT
5518 UNIVERSITY AVENUE
MADISON (608) 233-2200
ELEGANT DINING • FINE WINES • INTIMATE COCKTAIL LOUNGE • OPEN DAILY AT 5:30 PM
Awarded 4 chefs rating by the Milwaukee Journal
Voted Best Italian Restaurant 1985-86-87—MADISON MAGAZINE poll

"For an elegant night of Italian dining." —PROF HERBERT KUBLY, *Milwaukee Journal* writer

least 50% of his or her Medicare billings.

A preliminary RVS is to be developed by August 1, 1988 and will be implemented on January 1, 1989. When developing the RVS, HCFA has been directed to consider variations in the cost of furnishing services by geography and by service sites. The RVS should be developed on either a regional, statewide or carrier-wide basis. While the preliminary RVS is to be budget neutral, it will result in an aggregate 3% reduction upon implementation in 1989.

If a nonparticipating physician payment is based on the RVS, there will be further limits to the MAAC:

1989—125% of the amount specified in the fee schedule,
1990—120% of the amount specified in the fee schedule,
1991—115% of the amount specified in the fee schedule.

Pathology services. HCFA will develop an RVS to serve as a basis of payment for physician pathology services under Medicare Part B. HCFA will use the RVS and appropriate conversion factors in developing proposed fee schedules for use in 1990. The RVS is to be reported by January 1, 1989 and will take into account variations in the cost of furnishing pathology services among geographic areas.

The State Medical Society will be monitoring these changes as they develop. Look to the *Medigram* for further updates.■

Board approves AIDS recommendations

Three policy recommendations of the SMS Task Force on AIDS were approved by the SMS Board of Directors at its meeting, January 16, 1988.

The task force groups its recommendations in six categories: education, provision of care, funding, testing, confidentiality and public health measures. The three most recently adopted recommendations fall under provision of care and funding.

Under provision of care, the task force recommends a policy regarding the care of HIV-positive patients in nursing homes and home-care settings. The policy urges all nursing homes and home care agencies to prepare for the care of this new category of patients. It also outlines four steps the SMS should take toward this goal:

1) Urge county medical societies and medical directors to actively work with nursing homes and home-care agencies to identify issues, provide general education, set or programs and, if necessary, prepare for HIV-positive patients.

2) Recommend that in-service and educational programs focus on the fears of those in the industry, with the goal of relieving those fears by supplying facts and facilitating dis-

cussions; factual information about the disease, its transmission, and appropriate infection-control measures; and sharing experiences in developing the ability to care for HIV-positive patients—including such things as public relations, personnel policies, dealing with boards of directors, and other necessary policies and procedures.

3) Recommend in-service at two levels: individual staff programs and state programs for leadership staff, administrators, directors of nursing and medical directors.

4) Review Medicaid reimbursement criteria and offer revisions, if necessary, to provide adequate funding to these agencies and institutions for their services.

5) The other two recently adopted recommendations are in the funding category. The first recognizes the current and future costs of treating and caring for patients with AIDS- and HIV-related diseases, and endorses efforts to assure that Wisconsin receives its share of any funding provided by the Federal government for AIDS research, care and treatment.

The second recommended funding policy urges preservation of the protections provided by Wisconsin law, which prohibit group health care insurers from individual underwriting of policies or withdrawing coverage from an individual diagnosed as having an AIDS- or HIV-related disorder as long as all other contractual policy conditions are met. The policy also states that "SMS further believes that these same requirements and protections should apply to employers who self-insure, as well as other group insurance mechanisms which might not be covered by state law."

Finally, the policy encourages studies at the state and national level to determine how best to provide continuing health insurance coverage to individuals identified as HIV-positive or diagnosed as having AIDS- or HIV-related disorders.

Previously adopted recommendations

Education. These policies included making the education of health-care workers a priority for the Society; sponsoring or co-sponsoring statewide conferences; coordinating SMS efforts with those of other professional associations and health agencies; identifying a network of physicians to serve as an information resource; endorsing efforts to obtain a Federal grant for a midwestern AIDS Regional Education and Training Center; supporting mandatory AIDS education in Wisconsin public schools; and urging AIDS education in Wisconsin's private schools.

Provision of care. These included:

Health care workers have an ethical obligation to provide all patients with the same standard of care, including those with AIDS- and HIV-related disorders.

Health care facilities have a responsibility to provide education and

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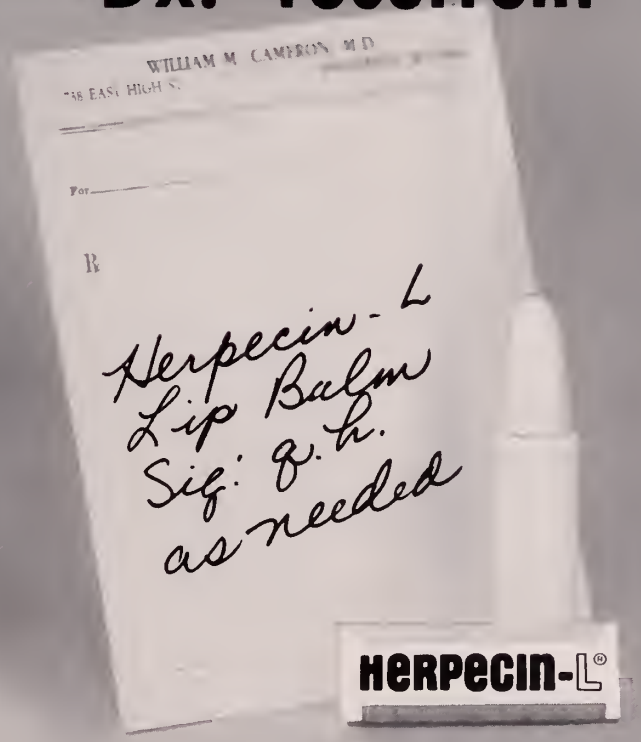

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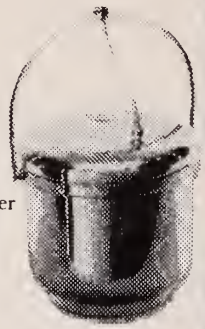

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materials, and to establish policies and procedures, to assure the safety of health care workers and other employees.

Health care workers have the duty to know and abide by the safety precautions, policies and procedures defined by their facility.

Patients have an obligation to inform their health care providers of positive HIV test results, and to honestly answer questions regarding their histories of high-risk behavior.

The presence of HIV infection or AIDS should not govern decisions of whether to care for patients for whom the facility would otherwise normally provide care.

Funding. First, to enable policy makers to make informed decisions, the SMS should encourage a study of cost projections for the treatment of AIDS and HIV patients in Wisconsin and the potential impact on both private and public payors.

Second, the SMS should encourage the state to explore the development of insurance for uninsured or underinsured HIV-positive patients.

Testing. These covered:

General population. Testing for HIV infection should be available to all Wisconsin residents who wish to be tested, free of barriers of cost, confidentiality and geography. Testing should be accompanied by counseling.

Blood and organ donors. Tests for HIV infections should be mandatory for donors of blood, blood fractions, organs and other tissues for transplantation, and sperm or ova for artificial insemination or *in vitro* fertilization.

Assaults. In assaults or other acts of physical aggression, which result in significant exposure of a victim to blood, semen or other body fluids, testing of the assailant for HIV infection should be mandatory. A court hearing should be held within 48 hours to determine whether the exposure warrants involuntary testing, and the significance of the exposure should be determined by a health care provider.

Exposure pursuant to provision of care. If a health care worker or emergency care provider has sustained a significant exposure to blood or body

fluids; if no HIV test has been performed, or test results are unknown or unavailable; and if, in the opinion of a physician, there is a reasonable possibility that a patient may have an HIV infection, the patient or the patient's legal representative should be encouraged to consent to HIV testing. If voluntary testing is refused, involuntary testing should be ordered, subject to appropriate due process procedures.

Deceased persons. State statutes should authorize testing of the blood of a deceased person—upon the order of a physician, county coroner or medical examiner—when an individual has sustained a significant exposure to blood or body fluids during provision of medical care prior to the patient's death, and when a post-mortem care provider sustains a significant exposure to blood or body fluids.

State statutes should also be amended to allow disclosure of HIV test results to coroners and medical examiners. (Such disclosure is already authorized for funeral directors.)

Mental health care. The clinical director of a state mental health institute or center for the developmentally disabled should be given the authority to order an involuntary HIV test in specific cases where such testing is warranted.

Hospital admissions. State statutes should authorize hospitals to test for HIV infection, without written consent, of patients admitted on an emergency basis. When establishing policies on routine testing—with patient consent—for nonemergency admissions, hospitals should consider their particular patient populations, the relative risk of AIDS infection and the recommendations of the Centers for Disease Control, the surgeon general and the Wisconsin Department of Health and Social Services.

Prison inmates. All inmates should be given information and counseling regarding AIDS and HIV infection and means of transmission, and should be offered testing. Testing should also be available to inmates upon request.

Involuntary testing should be ordered by the facility's medical director, or the warden upon a physician's advice, where warranted by a specific circumstance or incident.

State statutes should authorize disclosure of HIV test results to the medical staff of a jail or prison, the sheriff, the keeper of the jail and those in the chain of command with a direct need to know.

Confidentiality. State statutes should prohibit the subpoena or court-ordered disclosure of any list or roster of any persons tested for HIV infection or any communicable or sexually transmitted disease.

State statutes should clearly provide that all medical information contained in ambulance run records is confidential. Ambulance run records should be revised to include a section identifying any persons significantly exposed to blood or body fluids during emergency care, and the type of exposure that occurred.

Any school health records containing information regarding HIV infection should be separated from the remainder of the pupil record.

Public health measures. The Wisconsin Department of Health and Social Service should designate, by rule, "HIV infection" both as a communicable disease and as a sexually transmitted disease.

A complete report on the final recommendation of the SMS Task Force on AIDS may be obtained from Ron Henrichs, SMS Division of Communications, 608-257-6781 or 800-362-9080.■

WISPAC Luncheon speaker set

Michael E Dunn, president of Michael E Dunn & Associates, will be the featured speaker at the WISPAC luncheon, during the Annual Meeting, Friday, April 29, at 11:45 am.

A political scientist from Southern Arkansas University and North Texas State University, Dunn served as an instructor of political science at the University of Arkansas-Monticello. In Washington, DC, he was a legislative assistant to two US representatives before becoming director of government relations services for the Public Affairs Council. In 1976, Dunn founded Michael E Dunn & Associates, Inc. In addition to active membership in several professional public affairs organizations, Dunn is founder and past president of the Washington Area State Relations Group. He is also a well-known lecturer and leader of seminars and workshops on PACs, grass roots political action and political education.

One of Dunn's primary areas of expertise is the development of integrated grass roots programs for state government relations.■

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Theodore E Haglund, MD,* New Glarus, has become associated with Philipp H Marty, MD,* New Glarus, to provide medical services at the Blanchardville branch of The Monroe Clinic. Doctor Haglund graduated from the University of Minnesota Medical School and served an internship and residency at Bristol Memorial Hospital in Tennessee. Prior to joining Doctor Marty, Doctor Haglund had been a member of the medical staff at Community Health Center in Two Harbors, MN, and also served as chief-of-staff at Lakeview Memorial Hospital in Two Harbors, MN.

Michael Phillips, MD,* Wauwatosa, has joined the medical staff of Memorial Hospital, Oconomowoc, as chief of pathology. Doctor Phillips graduated from the Medical College of Wisconsin and completed his residency in pathology at the Medical College of Wisconsin affiliated hospitals, including Milwaukee County General and the Veterans Hospital, Wood. He is on the teaching staff of the Medical College and the University of Wisconsin Milwaukee School of Allied Health.

William G Richards, MD,* Beaver Dam, founder and president of the Beaver Dam Pathology Laboratory, subsequently called Consultant Physicians in Pathology, SC, retired at the end of 1987. Doctor Richards graduated from the University of Wisconsin Medical School, Madison,

continued next page

CES Foundation of the State Medical Society of Wisconsin

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin recognizes the generosity of the following individuals and organizations who have made contributions during the month of November 1987.

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followed by an internship and residency at Mercy Hospital in Des Moines, IA. Doctor Richards was a member of the medical staffs of Beaver Dam Community, Waupun Memorial, Hartford Memorial, Ripon Memorial, Divine Savior, Portage, Reedsburg Memorial, St Joseph's Memorial, Hillsboro, and Wautoma Memorial hospitals. He had served as president of the Dodge County Medical Society and the Wisconsin Society of Pathologists. Doctor Richards also had served as chief-of-staff at St Joseph's Hospital, Beaver Dam, and of Waupun Memorial Hospital.

AMA Physician's Recognition Award Recipients

LISTED BELOW are those physicians in Wisconsin who have earned the AMA Physician's Recognition Award in recent months. The State Medical Society of Wisconsin congratulates these physicians who have distinguished themselves and their profession by their commitment to continuing education.

JANUARY 1988

Ahn, Richard, Tomah
*Banker, Vincent P, Waukesha
*Biros, Dennis G, La Crosse
*Colan, Richard V, Milwaukee
Dhamee, Mohammed S, Milwaukee
*Erbach, Thomas J, Monroe
Fishman, Paul A, Milwaukee
*Francisco, Orlando M, Tomahawk
*Fullin, Kevin J, Kenosha
*Garrett, Kevin C, Appleton
*Gerber, Thomas G, Rice Lake
Haack, Dennis J, Madison
Harris, Gerald J, Milwaukee
*Hedlund, Patrick C, St Croix Falls
*Helminiak, Robert A, Sheboygan
*Hyndiuk, Robert A, Milwaukee
Jackson, Edgar B, Milwaukee
*Johnson, Raymond R, Wauwatosa
Kampschroer, Bernard H, Milwaukee
*Kim, Yong W, Elm Grove
*Klinger, Dean E, West Bend
*Martin, John E, Green Bay
Maski, Ravikant, Platteville
*Mayersak, Jerome S, Merrill
*Mnuk, Joseph F, Kenosha
*Parker, Marvin G, Racine
*Patel, Vasudev M, Monroe
*Peters, Stephen R, Woodruff
*Roberts, Richard G, Madison
*Sallis, Douglas A, Stanley
*Smalley, John J, La Crosse
*Suarez, Louis A, Appleton
*Wegenke, John D, Madison
*Wepfer, Joseph F, Wauwatosa
*Willis, Robert T, Sheboygan

*Members of the State Medical Society of Wisconsin ■

Kathryn A Phyfer, MD, Hartford, recently became associated with the Hartford-Parkview Clinic, Ltd. Doctor Phyfer graduated from the Chicago Medical School and completed her family practice residency at St Mary of Nazareth Hospital Center in Chicago. Doctor Phyfer was in private practice in Ellington, MO, and also served as the assistant director of the family practice residency program at St Mary of Nazareth Hospital Center, Chicago. She is a diplomate of the American Board of Family Practice and is a member of the American Academy of Family Physicians.

Karen S Wiringa, MD, Marshfield, has joined the medical staff of the Marshfield Clinic in the Department of Pediatrics as a neonatologist. Doctor Wiringa graduated from Northwestern University Medical School, where she completed her residency in pediatrics and had a fellowship in neonatology. She was assistant professor of the Department of Clinical Pediatrics, Obstetrics and Gynecology at Northwestern University Medical School and also practiced at Prentice Women's Hospital and Maternity Center/Northwestern Memorial Hospital.

Beth A Lepley, MD,* Monroe, recently became associated with the Monroe Clinic and has joined MDs William E Hein* and John W Rowe* at the Immediate Care Department at St Clare Hospital. Doctor Lepley graduated from the Medical College of Wisconsin, Milwaukee, and served her internship and residency at Waukesha Memorial Hospital. Doctor Lepley is Board-certified in family practice and Board-eligible with the American College of Emergency Physicians.

Hugo N Hunsader, MD,* Lake Mills, has retired from the medical staff of Countryside Home in Jefferson. Doctor Hunsader graduated from the University of Wisconsin Medical School, Madison, and served his internship at Madison General Hospital. He served in the US Air Force for two years and then opened a private medical practice in Fort Atkinson retiring in 1986. He was the medical director from 1969 until 1987 at Countryside and then became staff physician.

Mark Young, MD, Brookfield, has been appointed chief of the Medical College of Wisconsin's division of general internal medicine. Doctor Young graduated from the University of Michigan Medical School and served an internship at Henry Ford Hospital, Detroit, and a residency at the University of Michigan Hospitals in Ann Arbor. He previously had been director of health services research at the University of Michigan Medical School.

Joseph B Durst,* MD, and **Ruth Dalton, MD,** of La Crosse were recently awarded the Spheres of Influence Award by the St Francis Foundation. This award is presented each year by the Foundation to persons who have demonstrated outstanding commitment to health care within their spheres of influence.

Francis Kelly, MD, Cumberland, recently became associated with the medical staff of the Cumberland Medical Clinic and the Shell Lake Clinic. Doctor Kelly graduated from the University of Chicago School of Medicine and served his residency at the Albany Veterans Administration Hospital in New York. Prior to joining the Cumberland Clinic, Doctor Kelly practiced in North Dakota and Fairbanks, AK. Doctor Kelly is Board-certified in orthopedic surgery.

Axel Fuchs, MD, Merrill, recently joined Timothy C Klammer, MD,* Wausau, in the Central Wisconsin OB/GYN Associates located in the Bone and Joint Clinic in Merrill. Doctor Fuchs graduated from the University of Dusseldorf Medical School in West Germany and did residency training in Freiburg. Doctor Fuchs did research work in molecular endocrinology and completed his residency training in OB/GYN in Louisville, KY. ■

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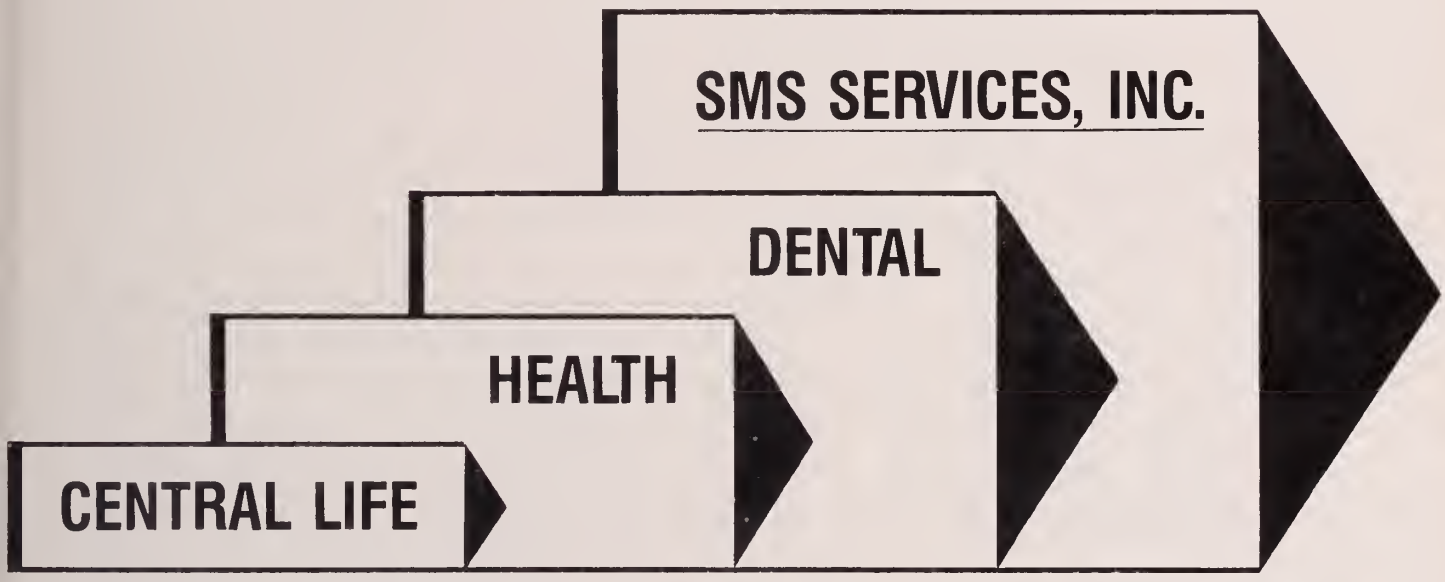

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COUNTY SOCIETIES

MANITOWOC: Twenty-eight members were present at the January Manitowoc County Medical Society to hear Don Lord, Manager Governmental Relations of the State Medical Society of Wisconsin, speak on "State and Federal Nursing Home Regulations."

MILWAUKEE: At the 141st Annual Meeting of the Medical Society of Milwaukee County, Donald P Davis, MD,* Milwaukee, was installed as president. He succeeds Anthony P Ziebert, MD,* West Allis, who served as president of both The Medical Society of Milwaukee County and the Milwaukee Academy of Medicine. These presidencies followed a year as president of the Wisconsin Society of Internal Medicine. Other MDs elected to office are Thomas A Reminga,* Milwaukee, president-elect and Marcia S Richards,* Milwaukee, who was re-elected secretary-treasurer. Doctor Ziebert has taken a seat on the Board of Directors. The membership also elected three new at-large members to the Board for three-year terms: Donald D Davidoff, MD,* Mequon; Peter S Foote, MD,* Milwaukee; and Christina C Keppel, MD,* of Milwaukee. Two past presidents of the Medical Society were given the organization's highest honor, the "Distinguished Service Award." They are MDs Jules D Levin,* Milwaukee, and Henry F Twelmeyer* of Elm Grove.

WINNEBAGO: James R Raymond, MD,* Oshkosh, was the guest speaker at the January meeting of the Winnebago County Medical Society. Thirty-eight members heard Doctor Raymond speak on "Civil War Medicine." Physicians accepted to membership in the Society are MDs Michael A Madden,* Dennis D Woodhall,* Menasha; Jill P Harman,* Neenah; and Ather S Siddiqui,* Bashar F Kayali,* and Mahmoud M Ahmed,* all from Oshkosh.■

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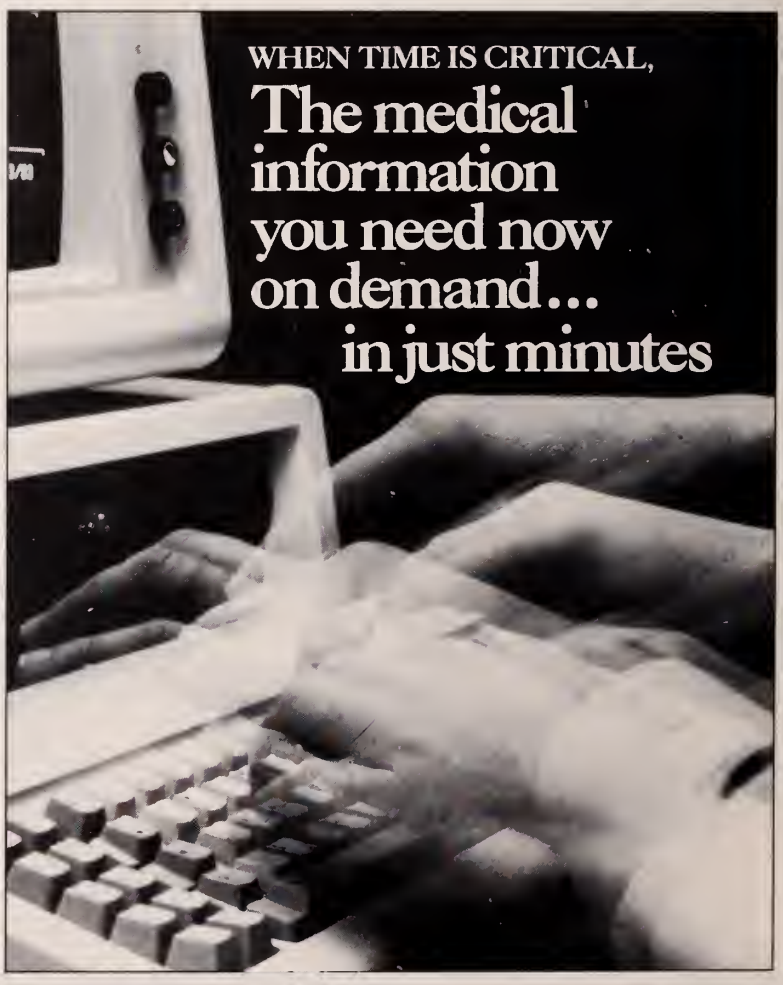

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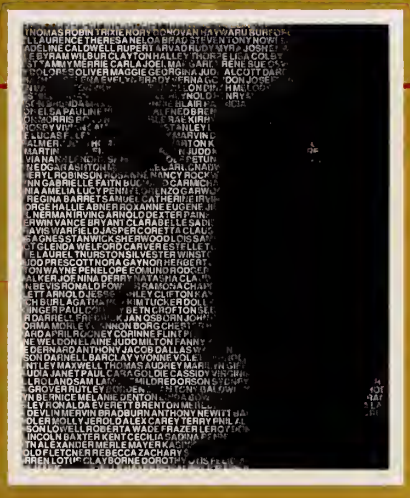

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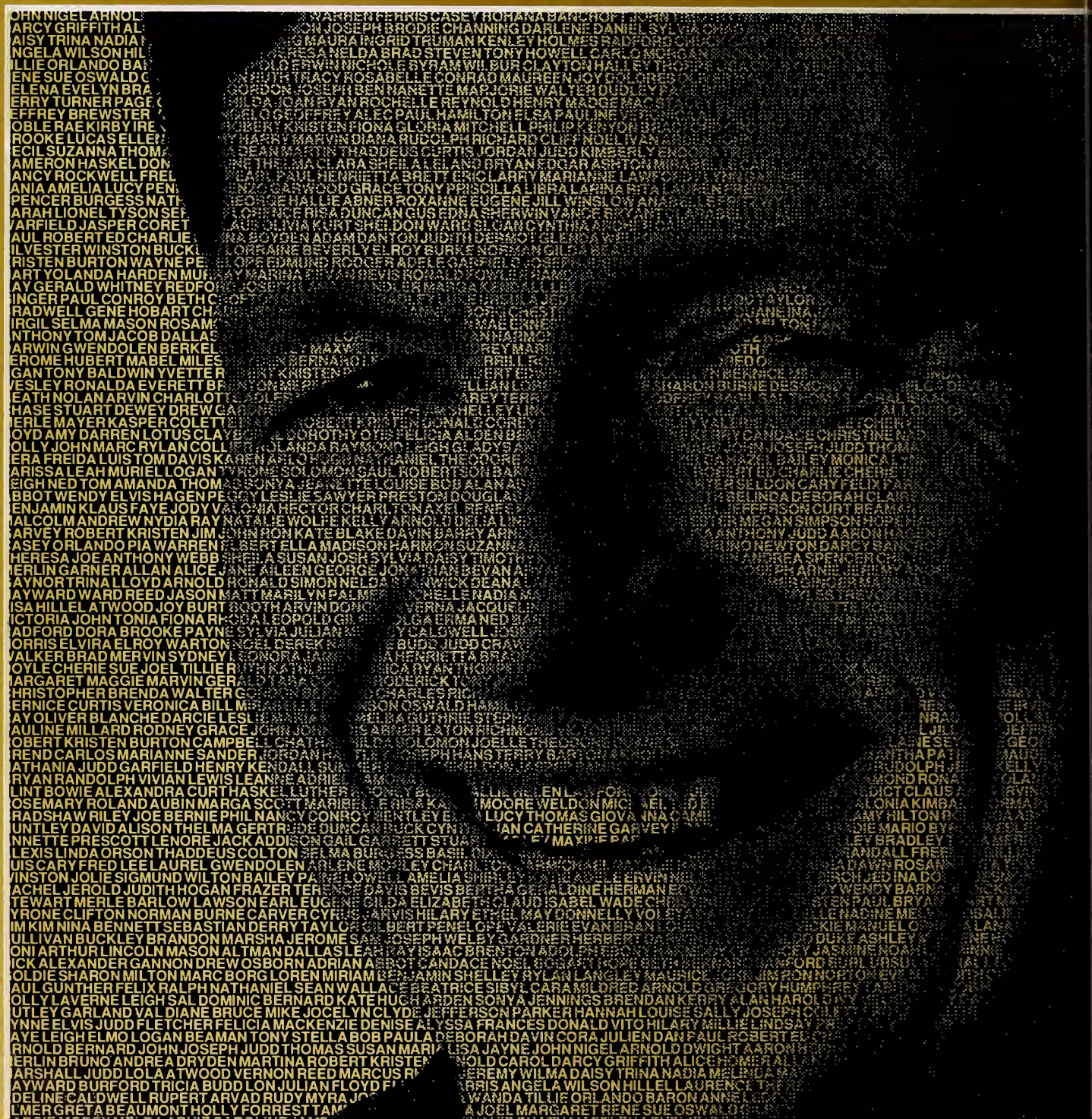

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INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure, and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3, and decreasing T_3.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL (propranolol HCl) is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, phenobarbitone, and *rifampin* accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and *lidocaine* have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

Reference:
1. Data on file, Ayerst Laboratories.

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State Medical Society of Wisconsin

Report of the
Strategic Planning Committee

January 1988

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In May 1987, the Board of Directors of the State Medical Society of Wisconsin approved a proposal that the Society develop a strategic plan. Such a plan would:

- identify the Society's fundamental purposes and strengths within a turbulent socioeconomic environment, and
- recommend initiatives for SMS to pursue that further its mission and capitalize on its strengths.

To assist it in developing the plan, the Society engaged Health Policy Research Group, a Chicago-based consulting firm that later merged with the accounting firm of Coopers & Lybrand.

The Board agreed that direct membership involvement in the planning process would increase the likelihood that the plan that is developed will meet Wisconsin physicians' future needs. Therefore, it assigned the SMS Executive Committee to prepare the plan along with senior staff, and added to the committee physicians who represented the broad spectrum of interests and perspectives in the Wisconsin medical community.

Beginning in August, the Strategic Planning Committee met to:

- review the Society's major activities over the past decade,
- analyze the medical practice environment in Wisconsin and examine the opinions and expectations of SMS members about the Society,
- review the Society's mission to ensure that it can meet SMS's needs in the future,
- establish priorities for SMS's functional areas, and
- recommend initiatives for the Society within each functional area.

The following report presents the committee's conclusions and recommendations to the Board.

I. Review of past and present SMS activities

As a first step, the committee identified and discussed those activities that the Society has undertaken in the past decade. By so doing, the committee was able to assess SMS's operating priorities, its successes and failures, and its strengths and weaknesses. This review yielded several insights of importance to the strategic planning process:

- SMS has operated under an extremely broad agenda, from representing physicians' interests to state government, to sponsoring and accrediting continuing medical education programs, to providing members with specific services. SMS members expect the Society to deliver in each of these areas. In some sense, these expectations demonstrate the extent of SMS's success; in addition, they show that the Society's future is not dependent on a single program or service. On the other hand, the Society's broad compass may dissipate its effectiveness in each area. As one senior staff on the committee noted, the goals of the Society "often are set by 5,000 bosses."
- SMS throughout the years has scored major successes in representing the profession at the state legislature. For example, in the last legislative session, SMS worked to:

—preserve the access of the elderly to health care by promoting continued voluntary Medicare assignment,
—contain efforts by limited license practitioners to provide services beyond the level of their competence,
—maintain physicians' authority to prescribe drugs by brand,
—promote safety issues, such as seat belt use, and
—defeat imposition of sales tax on patients.

The Society has been increasingly successful in "managing" legislative issues, by building credibility with key legislators, mobilizing a physician key contact system, and setting its legislative priorities.

- SMS has also been successful in influencing regulations promulgated by state agencies. It has been invited to participate in the development of regulations because it has established its own professional credibility and affirmed the social conscience of Wisconsin physicians. For example, the PartnerCare program, co-sponsored with the Coalition of Wisconsin Aging Groups to provide affordable care to the elderly poor, has been instrumental in preventing more onerous restrictions on practicing physicians. Nevertheless, SMS has been limited in what it can accomplish on behalf of physicians in a state as consumer-oriented as Wisconsin, a prime example being the Society's failure to influence effective reform of the Medical Examining Board's system of review and discipline.
- On a related issue, it was the perception of the committee that the public has only a vague conception of SMS, its purpose and programs. Many believed that most Wisconsin residents, to the extent they are at all aware of the Society, assume that it is a state governmental agency. Although convenient on certain occasions, this misunderstanding hampers SMS's ability to further its mission in most other cases.
- The lingering professional liability issue illustrates many of SMS's strengths and weaknesses, which will come into sharper focus in the future. The Society's extensive efforts in the legislative arena have largely been successful. The Society perceived a major problem a few years ago and took effective action to address it. Act 340, passed in 1986, was a start in the right direction and was preferable to the available alternatives. Even so, there have been elements of real and perceived failure on SMS's part. Some SMS members perceive that the Society has failed because it has not achieved all of its aims (eg, a lower cap on noneconomic damages). In addition, SMS finds it difficult to receive due credit for preventing or delaying problems (eg, an even higher escalation of premiums) that would have occurred without its

actions. In reality, SMS faces formidable opposition to its position and is hindered by a lack of consensus within organized medicine in Wisconsin. Most likely, these real and perceived problems will loom large as the professional liability issue is addressed in the future.

II. The opinions of SMS members about the Society and the medical practice environment

In approving the development of a strategic plan for the Society, the Board felt that the Strategic Planning Committee needed to hear directly from as many physicians as possible. To this end, the Board authorized a survey of the entire SMS membership to elicit their opinions about the Society and its priorities for the future. In addition, the afternoon session of the Society's 1987 Leadership Conference was devoted to a discussion of the practice environment in Wisconsin, the role of SMS, and its future directions. The following summarizes the findings of these activities.

A. Results of membership survey

A mail survey was conducted in August and September of all 5,027 regular SMS members. The results of the survey were analyzed by Coopers & Lybrand, and its report is attached as an appendix of this report.

Several of the survey's findings deserve special mention because of their relevance to the Society's strategic plan:

- Of the 13 issues (listed in the survey) of potential concern to SMS members, the professional liability/malpractice issue is by far the most important. Issues related to professional autonomy (government regulation of medicine, third-party payor involvement in medical decisions) are also of great importance to SMS members. Finally, respondents to the survey cited the public image of the medical profession as an important issue.
- SMS is accorded a high overall rating by its members, with over three-quarters of those responding citing it as "good" or "excellent." Its approval rating is close to that given to specialty societies, a result rarely found in similar surveys conducted for other state medical associations. However, the AMA and county medical societies receive a much lower rating, a finding that may hinder SMS's ability to achieve its goals by working with the Federation.
- SMS members view the Society as being responsive in dealing with change. Nevertheless, almost two-thirds think that it should adopt an even more progressive posture along this dimension. (Most think that the other components of organized medicine need to be more progressive, as well.)
- Although SMS members give the Society strong support in general, they do not uniformly praise its performance in each of its eight broad functional areas. From best to worst, their ranking is:
  - —communication with the profession,
  - —legislative (lobbying) efforts,
  - —political candidate support (WISPAC),
  - —member benefit programs (insurance, leasing, etc),
  - —socioeconomic activities,
  - —scientific and educational activities,
  - —consulting services to the membership (medical/legal, contracting, etc), and
  - —communication with the public.
- Communicating and representing medicine's views to others (ie, state legislators, Congress, regulatory agencies, the public) define what could be called the Society's "core attributes," that is, the activities that constitute what the members want most from SMS.
- WISPAC, helping physicians deal with third-party payors, the impaired physician program, and SMS publications represent the Society's "augmenting attributes," which complement and expand upon its core attributes.
- Six Society activities listed in the survey can be considered "peripheral attributes," based on members' responses: patient brochures; member insurance programs and discount plans; CME opportunities; the CES Foundation; practice management services and financial planning seminars; and the Fort Crawford Medical Museum. These activities appeal not to the membership at large, but rather to specific kinds of SMS members.
- Of 15 potential services and programs mentioned in the survey that could be provided by SMS, county medical societies, hospitals, private vendors, or others, SMS is the preferred source for eleven by a plurality of members. For five of these, a clear majority prefers SMS over other organizations. These striking results show the depth of membership support of (and confidence in) SMS. They also indicate that the Society has a multitude of avenues for expanding its service to members, both for the entire profession and for individual members.

B. Results of Leadership Conference breakout sessions

To amplify and probe the results of the membership survey, the afternoon session of the 1987 SMS Leadership Conference was devoted to a discussion of the future of the Society. Four simultaneous "breakout sessions" were conducted by SMS officers, to facilitate a full and vigorous discussion. The sessions largely confirmed the survey results, even though the conference participants were not a true random sample of SMS members. (However, as local medical society leaders, they did accurately represent the views of "grassroots" physicians.)

Despite the overall consonance between the survey and breakout sessions, several comments at the sessions relevant to the planning process should be highlighted:

- Most session participants stated that Wisconsin has a good environment to practice medicine. Although "not the place to make a fortune," the life-

style, "spiritual" benefits, and strong patient/physician relationships still make the state attractive.
• Overall, participants said that medicine is still "fun," fun, that is, to treat patients but not to run a business. Litigation is "frightening," the paperwork is hard to deal with, and the debts facing young physicians are "unbelievable." Because of these pressures, the participants were concerned about physician morale.
• As expected, session participants strongly supported SMS, citing it as "*the* organization to join because of its ability to respond to issues." They praised its innovations (such as PartnerCare) and said that it was one of the most active state medical associations in the country. SMS and specialty societies were seen as comparable in effectiveness, again, a result not evident in many states.
• In addition, physicians noted that the most important issues of concern to them were occurring at the state level. Not surprisingly, then, they rated SMS's lobbying and representational activities as the most important to them. WISPAC, as expected, generated some controversy, with some criticizing its support of a single unsuccessful candidate in the last election and others defending the PAC's overall record.
• As to other SMS activities, participants praised the Society's publications (especially *Medigram*). Member services were viewed as "frosting on the cake," but important in providing members with a tangible benefit. Little support was expressed for reducing or discontinuing what were called "peripheral attributes" above.
• The general tenor of recommendations from the sessions for the future was for the Society to perform its current activities even more effectively *and* to take on new programs. SMS should take a progressive posture to the changes that are occurring in medicine, but be selective about the changes it supports and fosters.
• There was some sentiment that SMS should direct its programs to members only, rather than the Wisconsin physician community at large. Nonmembers should be either denied access to SMS services or charged a hefty premium for access.
• The issue of the physician's image pervaded much of the discussion at the sessions. SMS was urged to articulate the credibility of physicians—to the public, business and industry, and legislators. Some stressed the importance of promoting the image of physicians to themselves, noting that many physicians feel harassed and unappreciated.

III. The mission of the State Medical Society of Wisconsin

In reviewing the Society's past and present activities in the context of the results of the membership survey and Leadership Conference breakout sessions, the Strategic Planning Committee identified a number of challenges facing SMS in the future:

• Presenting a unified front on major public policy issues.
• Handling issues when no consensus exists among members.
• Managing the expectations of the membership, especially when the Society must operate in a non-medical environment in which "reason does not sell."
• Continuing to refine SMS's ability to respond to issues expeditiously in times of rapid change.
• Maintaining and increasing levels of service, given more severe constraints on dues increases.
• Meeting the professional needs of an increasingly diverse physician population.
• Working more effectively with all components of organized medicine (county, AMA, and specialty societies).

The committee recognized that the strategic plan it developed must address these challenges. Therefore, it decided to re-evaluate the basic purposes of the Society, to ensure that SMS has a clear and relevant mission.

The committee began this process by reviewing the Society's current mission, as stated in Article II of the Constitution:

> **The purpose of the Society is to bring together the physicians of the state of Wisconsin to advance the science and art of medicine, to better the health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws.**

After considerable discussion, the committee could find few flaws with this statement. It is clear, succinct, defensible, honest, and—most of all—relevant to the demands that Wisconsin physicians are likely to place on the Society in the years to come. The statement identifies that SMS exists to unify the medical profession in this state. It also enunciates the Society's twin roles, as a scientific and professional association and as a representative of physician interests to government.

For these reasons, the Strategic Planning Committee recommends that the State Medical Society of Wisconsin ratify its current mission.

IV. SMS's priority functional areas

Using the mission statement and the committee's earlier analysis, it thoroughly evaluated SMS's current activities and broad functional areas. It determined that *no existing SMS program or activity should be curtailed or eliminated.* This finding surprised the committee somewhat, because one of the initial motivations for undertaking strategic planning was to identify ineffective or irrelevant SMS programs. Instead, the committee found that each activity, from representing medicine's views to state legislators to operating a museum of medical progress, plays an important role in fulfilling the Society's mission.

On the other hand, the committee recommends that SMS reorder its priorities for its eight functional areas. In view of the mission statement and recognizing the strengths and weaknesses of the Society and the demands of its members, SMS's priorities should be:

1. Representation to the government.
2. Communication with the profession.
3. Communication with the public.
4. Socioeconomic activities.
5. Member benefit programs.
6. Political candidate support.
7. Scientific and educational activities.
8. Consulting services to the membership.

The major change between this priority and SMS members' ranking of the Society's current performance (see page six above) is that SMS will place more emphasis on communicating with the public, the area in which members believe that the Society now does worst.

The following section describes each functional area and outlines recommended new initiatives for the Society to undertake. Because the committee recommends no diminution in current activities, these initiatives must be financed by either dues increases or expansion of those services that generate non-dues revenue. Regardless of the financing source, SMS needs to implement the initiatives within the next three years if it is to remain a progressive force for medicine in Wisconsin.

Priority 1: Representation to the government

The committee was nearly unanimous that representation to the government of the public's health care concerns and of physicians' interests must receive SMS's highest priority. This ranking reflects the Society's mission and exploits its major strengths and the source of its most prominent successes. The secretary-general manager and senior staff, in consultation with SMS leadership, will determine the Society's specific tactics within this area. Attention should be given, however, to the following:

Ongoing Activities

- Representation of the profession's interests to the state legislature.
- Representation of the profession's interests to state regulatory agencies.
- Review and analysis of proposed legislation and regulations.
- Establishment of priorities for legislative action.
- Involvement of the membership in SMS's legislative and regulatory objectives, through the key contact network.
- Liaisons with other organizations to build coalitions and gain support for SMS's objectives.

Initiatives for the Future

- Expand SMS's presence with the Wisconsin Congressional delegation, both in Washington and in the districts.
- Expand active lobbying efforts on those federal issues, both legislative and regulatory, that have major regional implications.
- Interact with HCFA on generic issues confronting Wisconsin physicians.
- Enhance the Society's ability to interact with *all* state agencies that affect the health of the public (including the Department of Transportation, Department of Public Instruction, and Medical Examining Board).
- Expand efforts to educate physicians about the political process, including development of political education seminars.
- Expand the physician key contact network, working through county medical societies, the Auxiliary, and other constituent groups, where possible.

Priority 2: Communication with the profession

SMS does an exemplary job of keeping its members informed about important issues and Society activities. *Medigram*, in particular, is an excellent publication that commands a wide readership. Given the importance of maintaining and strengthening physician support for the Society, SMS should seek opportunities to improve its communications efforts even further.

Ongoing Activities

- *Wisconsin Medical Journal.*
- *Medigram.*
- "Capitol Update."
- Special mailings about important, late-breaking issues.
- Informational brochures (similar to "The Ethics of Less Care," "Guide to Pre-Admission Screening," and "A Guide to Medicare Audits").
- Annual Leadership Conference.
- Liaison with county medical societies and members through network of field representatives.
- Physician Support Group, to help physicians facing malpractice suits.

Initiatives for the Future

- Initiate a campaign to improve the image of the profession within the profession.
- Establish new mechanisms (eg, through hospital medical staffs or state specialty societies) for reaching physicians where their interests lie.
- Create a mechanism to allow membership participation in the annual process of setting legislative priorities.
- Develop methods to assist members in communicating with patients regarding socioeconomic and legislative issues.
- Develop a program to encourage physicians and their spouses to become more involved in community activities and service organizations.
- Assist county medical societies and other constituent groups in communicating more effectively with local physicians.

Priority 3: Communicate with the public

SMS needs to improve its level of communications with the people of Wisconsin. At the very least, it needs to establish its identity with the public. In this sense, SMS's "public" includes key decision-makers, individuals and groups that could be interested in specific Society activities, and even physicians themselves. More importantly, it should promote the activities of the Society designed to improve the public's health and seek to improve the image of the medical profession in Wisconsin. SMS should not, however, engage in an extensive advertising campaign, which would expend valuable resources with little tangible, long-term gain.

Ongoing Activities

- The REACH Program (Resource for Education and Awareness of Community Health):
  —Speaker's Bureau,
  —Media contacts,
  —Public service announcements, and
  —*Healthwatch* newsletter.
- Informational brochures (similar to "Getting the Most Out of Your Health Care Dollar" and "If You Have a Complaint About Medical Care").
- Auxiliary activities such as health education workshops (on topics such as teen suicide, substance abuse, teenage sexuality).

Initiatives for the Future

- Publicize the accomplishments of Wisconsin physicians, both clinical/scientific and community-oriented.
- Publicize SMS efforts to improve the quality of care, eg, CME, peer review, impaired physician program, patient complaint system, support of public health legislation.
- Publicize SMS efforts to improve the public's access to care, eg, PartnerCare, placement service.
- Promote to the public SMS's position on issues such as public health and safety, AIDS, and liability reform.
- Assist county medical societies, the Auxiliary, and other constituent groups in communicating more effectively with their "publics."
- Stimulate county medical societies and other constituent groups to work more closely with local news media, through such vehicles as public relations guides, "canned" news stories, and spokesman training.

Priority 4: Socioeconomic activities

SMS is the most active physician organization in the state in addressing socioeconomic issues. Its various liaisons with other organizations, PartnerCare, and the formation of PIC-Wisconsin represent the diversity of SMS activity in this area. SMS must maintain this leadership position, for the benefit of its members and for its own future.

Ongoing Activities

- PartnerCare.
- Liaisons with Wisconsin Hospital Association, WIPRO, Coalition of Wisconsin Aging Groups, Wisconsin Nurses Association, State Bar of Wisconsin.
- Impaired physician program.
- Commission on Mediation and Peer Review:
  —Mediation of patient complaints, and
  —Evaluation of physician practice patterns.
- Medicaid Medical Audit Committee.
- Participation in AMA activities.
- Monitoring and analysis of proposed changes in public health care policy.
- Identification and analysis of emerging socioeconomic issues.

Initiatives for the Future

- Take the initiative in assuring that the profession consists only of physicians able to practice high-quality medicine. Assist hospital medical staffs and other physician groups in conducting appropriate peer review and credentialing to uphold these standards.
- Stimulate the development of alliances to pursue common goals, with such organizations as the Wisconsin Hospital Association, Wisconsin Association of Manufacturing and Commerce, labor unions, senior citizen groups, state medical schools, universities, and specialty societies.
- Conduct primary and secondary research on emerging socioeconomic issues, for use in preparing internal studies and policy positions.
- Conduct membership surveys to provide information for policy development and to improve SMS's communication with physicians.

Priority 5: Member benefit programs

Direct member services, such as insurance and discount programs, fall into the category of "peripheral attributes" of the Society. Nevertheless, they add value to SMS membership. As the membership survey indicated, members prefer SMS over other potential suppliers of these services, either because SMS has earned a reputation for reliability or members expect their state medical association to be a "full-service" organization. For the Society's part, these services generate needed non-dues revenue, tie-in member support (eg, PIC-Wisconsin liability insurance), and improve membership retention.

Ongoing Activities

- Membership tie-in with Physicians' Insurance Company of Wisconsin.
- Insurance programs (health, life, disability, business expense and overhead, auto, homeowners, personal).
- Endorsed programs (equipment leasing/purchase, auto rental/leasing, workers' compensation insurance, computer hardware and software, collection service, credit cards).

• Miscellaneous services (uniform claim forms, printing, association management).
• Physician placement service.

Initiatives for the Future
• Actively explore new services to offer to SMS members that are consistent with the Society's mission and that require SMS membership as a condition of participation.
Alternatives include:
—electronic claims processing,
—physician credential information clearinghouse,
—new practice management seminars,
—temporary personnel services,
—discount group purchasing services, and
—travel agency.

Priority 6: Political candidate support

WISPAC is an integral part of SMS's program to represent physicians' interests in state and federal government. Despite controversies surrounding the support of particular candidates, SMS members rate highly the Society's performance in this area. SMS must continue to use the PAC to promote the election of candidates who merit physician support.

Ongoing Activities
• Promotion of membership in WISPAC and Physicians for Better Government.
• Interview, endorsement, and support of candidates who back SMS's legislative program.
• Encouragement of physician and family participation and increased visibility in political campaigns.

Initiatives for the Future
• Expand political education efforts.
• Expand local involvement in WISPAC candidate interviews and endorsements.
• Expand local activities (eg, fundraisers) to support particular candidates or elected officials.
• Encourage physician contributions to AMPAC.

Priority 7: Scientific and educational activities

SMS has a long tradition of supporting scientific and educational programs, especially through the CES Foundation. Other organizations, such as specialty societies, hospitals, and medical schools, have become increasingly active in educational endeavors. Nevertheless, because of its mission, SMS has a continuing responsibility to encourage the advance of medical knowledge and to convey the heritage of medicine in Wisconsin. Therefore, the Society should maintain its presence, through sponsoring and accrediting CME courses, operating the Fort Crawford Medical Museum, and other activities.

Ongoing Activities
• Charitable, Educational and Scientific Foundation.
• Fort Crawford Medical Museum.
• CME accreditation.
• Scientific program at Annual Meeting.
• Loan program to medical students.
• Public health committees:
—Aging, Extended Care Facilities, and Home Health Care;
—Alcoholism and Other Drug Abuse;
—Environmental and Occupational Health;
—Maternal and Child Health;
—Medicine, Religion, and Ethics;
—Mental Health;
—Safe Transportation; and
—School Health.
• Task Force on AIDS

Initiatives for the Future
• Initiate programs within the Foundation and the Museum to publicize the contributions of physicians and the medical profession and to promote medicine's accomplishments to the public.
• Explore new programs to assist those interested in pursuing careers in medicine.
• Provide program assistance (eg, a speakers' bureau) to specialty societies and county medical societies on scientific and socioeconomic topics.

Priority 8: Consulting services to the membership

As with member benefits, SMS's consulting services represent peripheral attributes of the Society. However, programs such as consultations on PRO and Medicare audits, risk management seminars, and contract review are valued highly by a significant minority of Society members. Therefore, for the same reasons as cited in *Priority 5* above, SMS should maintain its efforts in this area. To emphasize the benefits of SMS membership, nonmembers should be allowed to use these services—but at a premium price.

Ongoing Activities
• Contract review.
• Seminars on such topics as risk management, practice management, and financial planning.
• Consultations on PRO and Medicare audits.
• Resolution of insurance coverage and payment disputes between physicians and third-party carriers.

Initiatives for the Future
• Actively explore new services (eg, consulting on federal programs, contracts, and loss prevention/risk management) to provide to SMS members that are consistent with the Society's mission.
• Act as a clearinghouse of relevant services and information provided by other medical societies (eg, AMA, specialty societies) and organizations.■

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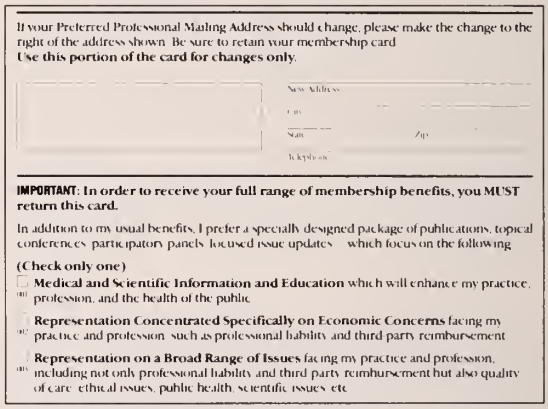

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Membership Directory—Update

The following information is being provided from Membership reports and from individual members for updating the 1987 Membership Directory as published in the July 1987 issue of the *Wisconsin Medical Journal.* Because of space limitations address changes and phone numbers will not be included in this Update; however, they will be changed in Membership Records. County transfers will be included when processing has been completed by Membership Records. **Changes in practice specialties** (as used by the AMA) and changes in **Board-certified specialties** as listed by the American Board of Medical Specialties (see July 1987 Membership Directory) are included. **Practice specialties** appear before the slash (/) and **Board-certified specialties** appear after the slash.

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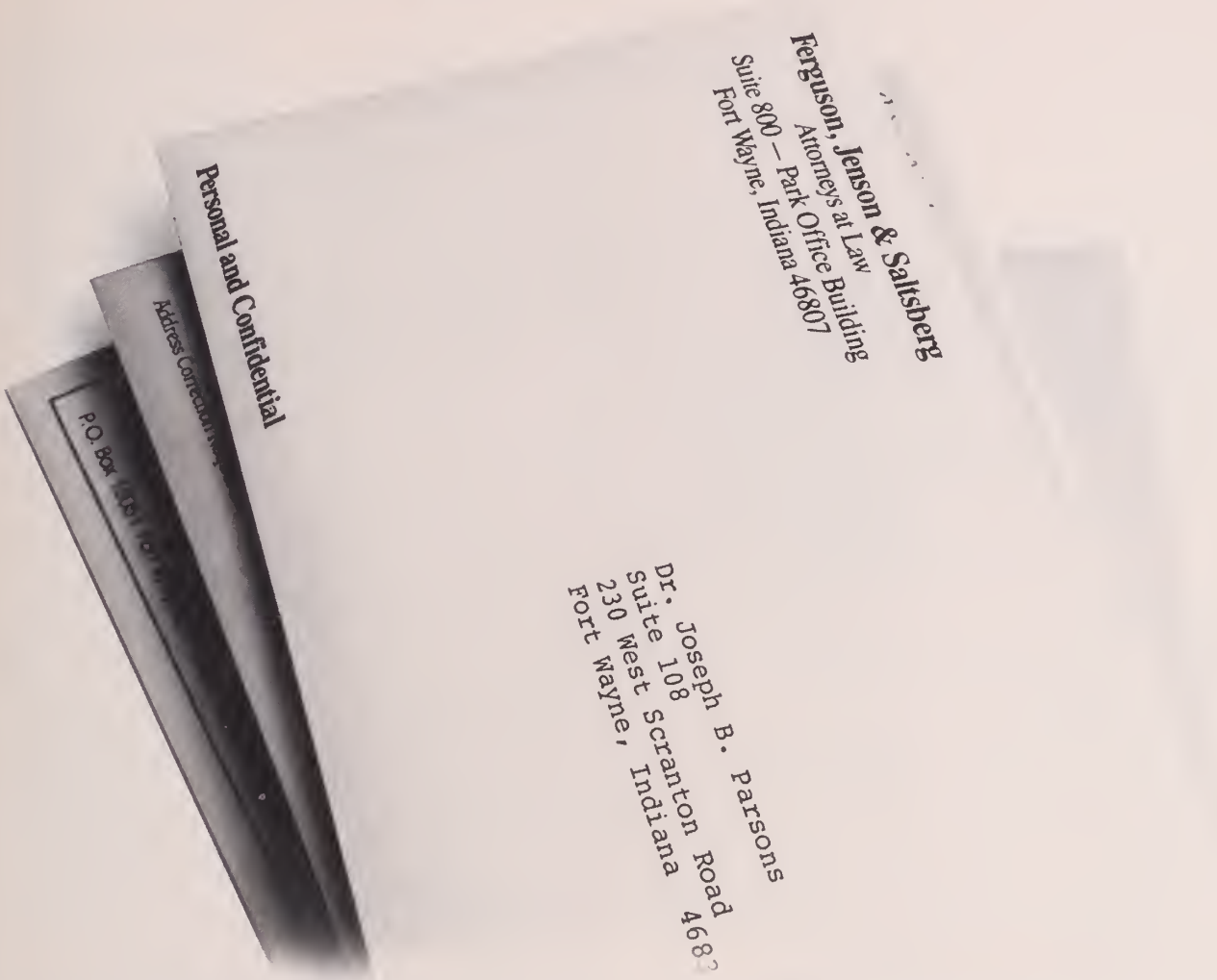
Crisis in black and white.



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SURGERY OF THE AORTA

Edited by

L. Douglas Cowgill, M.D.

MARSHFIELD CLINIC, Marshfield, Wisconsin

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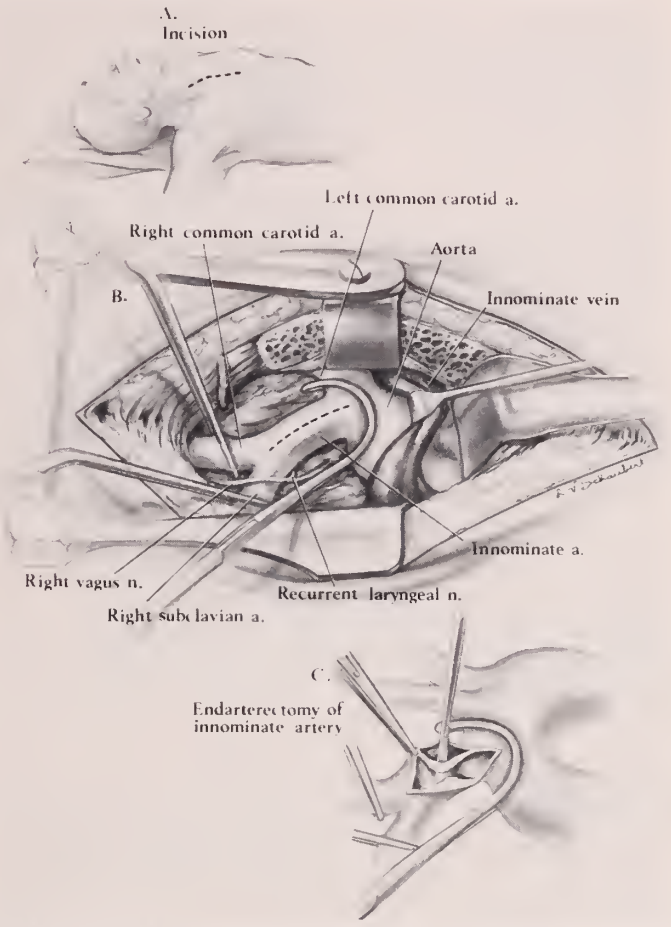

Incision (A), exposure (B) and technique (C) in endarterectomy of lesions in the innominate and right subclavian arteries through a median sternotomy (From Oloffson and Ehrenfeld, *Surgery of the Aorta*.)

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OBITUARIES

John L Rens, MD, 84, Madison, died Dec 3, 1987 in Madison. Born Jan 22, 1903 in Oconto, WI, Doctor Rens graduated from the University of Minnesota Medical School and served his internship and residency at Minneapolis General Hospital. Doctor Rens practiced medicine in Phillips until 1969 when he retired. He was a member of the Dane County Medical Society, State Medical Society of Wisconsin and American Medical Association. Surviving is his widow, Norma, of Madison.

William A Fischer, MD, 79, Frederic, died Dec 13, 1987 in Frederic. Born Sept 3, 1908 in Ripon, Doctor Fischer graduated from the University of Wisconsin Medical School, Madison, and served his internship and residency at Madison General Hospital (now Meriter). He served in the United States Army during World War II. Doctor Fischer was a member of Polk County Medical Society, State Medical Society of Wisconsin, and American Medical Association. Surviving are his widow, Adelaide, and three children: Ted, Eau Claire; Tom, Holland, MI; and Laurie of Des Moines, IA.■

NEWS YOU CAN USE

WisconCare continues

WisconCare, successor to the ShareCare program, has begun a second period of funding dating from September 1, 1987 to June 30, 1989. A survivor of the State Budget, the program, which is administered by the Wisconsin Primary Health Care Association, continues as an innovative, cooperative public-private effort to bring health care services to uninsured residents in 17 counties in Wisconsin while a more comprehensive, widespread solution is sought.

While funding was essential for continuation, equally important was the willingness of physicians to provide services to enrollees. "Without this component—physician cooperation— there would not be a WisconCare," said Sarah Hanson, WisconCare program director. "The new period of funding required new agreements from all providers. It has been gratifying that most physician contracts have been renewed. Presently, we have 339 contracts representing 1,458 physicians as well as contracts with 251 pharmacies and 45 hospitals. This sustained commitment certainly is indicative of a caring, concerned medical community. We are also grateful for the clients whom providers have referred to the program which further strengthens this unique partnership."

Counties involved in the program are: Brown, Door, Douglas, Forest, Kenosha, Lincoln, Milwaukee, Oconto, Oneida, Portage, Price, Sawyer, Shawano, Vilas, Washburn, Waukesha and Waushara. Physicians who are located within these counties and are not part of the program may, if interested, call 715-387-9136 for further information.■

BLUE BOOK/UPDATE

On page 167 of the June 1987 issue of ***WMJ*** under the SMS Physicians Alliance Commission, Joseph L Teresi, MD, Brookfield has resigned.

On page 168 under the SMS Commission on Public Information, Vinoo Cameron, MD, Medford, and Carl R Poley, MD, Green Bay, have resigned.

On page 176 under the Presidents and Secretaries, Wisconsin Specialty Societies, the following changes should be made for the Wisconsin Chapter, American College of Emergency Physicians:

(October 1989)
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VP—Albert S Yee, MD
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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it, however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

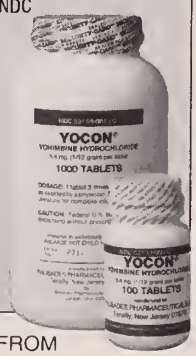
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



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1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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BRIEF SUMMARY

CONTRAINDICATIONS
There are no known contraindications to the use of sucralfate.

PRECAUTIONS
Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that the simultaneous administration of CARAFATE with tetracycline, phenytoin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. The clinical significance of these animal studies is yet to be defined.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No evidence of drug-related tumorigenicity was found in chronic oral toxicity studies of 24 months' duration conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies have not been conducted.

Pregnancy: Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients, adverse effects were reported in 121 (4.7%). Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

DOSAGE AND ADMINISTRATION
The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED
CARAFATE (sucralfate) 1-gm pink tablets are supplied in bottles of 100 and in Unit Dose Identification Paks of 100. The tablets are embossed with MARION/1712 Issued 3/84

References:

1. Grossman MI: *Scand J Gastroenterol* 58 (suppl 15):7-16, 1980.
2. Marks IN, in Hellemans J, Vantrappen G (eds): *Gastrointestinal Tract Disorders in the Elderly* Edinburgh, Churchill Livingstone, 70-81, 1984.
3. Krentz K, Jablonowski H, in Hellemans J, Vantrappen G (eds): *Gastrointestinal Tract Disorders in the Elderly* Edinburgh, Churchill Livingstone, 62-69, 1984

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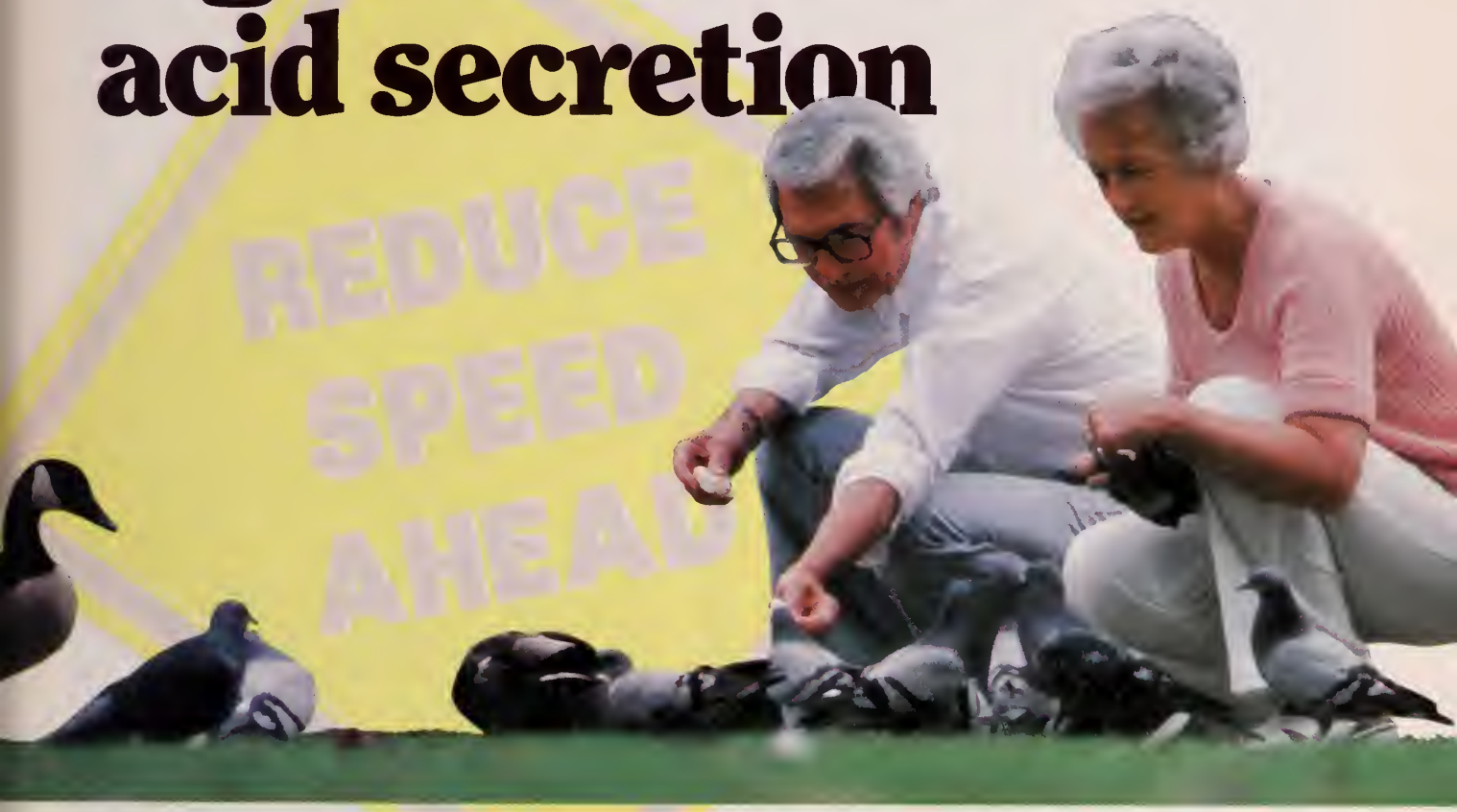
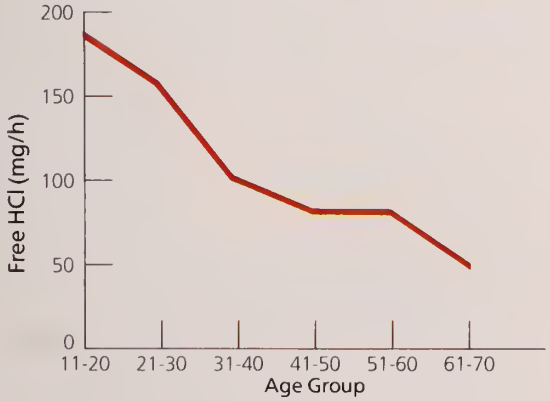


If your duodenal ulcer patient is over 55, decreased mucosal resistance is more likely to cause an ulcer than hypersecretion of acid-pepsin.[1] A tendency toward lower acid secretion with advancing age has been shown.[2,3]

Declining gastric secretion and age[3]



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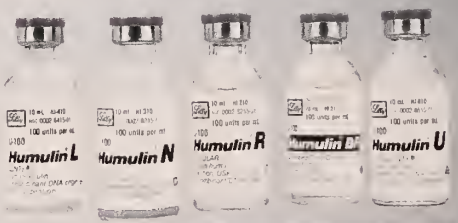

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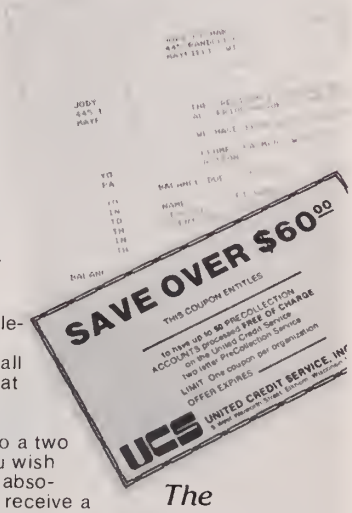

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NEWS HIGHLIGHTS

Quarles & Brady law firm, Milwaukee, has announced that Robyn S Shapiro recently became associated with the firm. Ms Shapiro also will remain a faculty member at the Medical College of Wisconsin and director of its Center for the Study of Bioethics, a position she has held since 1985. She was one of the authors of the article "Living will in Wisconsin" that was published in the October 1986 issue of the *Wisconsin Medical Journal.*

Kettle Moraine Hospital's Beaver Dam Clinic has appointed Timothy J Rentmeester, MD,* Beaver Dam, Director of Medical Services. He graduated from the University of Wisconsin School of Medicine, Madison, and served his family practice residency at St Luke's Hospital in Milwaukee. He became associated with the Medical Associates of Beaver Dam in 1986 and continues to be a member of its medical staff.

St Nicholas Hospital's medical staff, Sheboygan, recently elected the following physicians to head its staff for the year 1988-1989. They are MDs John F Schwalbach,* president; William G Wagner,* vice president; and Sarah J Pratt* as secretary-treasurer. James B Kuplic, MD,* who served as president for the past two years, will act as an advisor to the president.■

Membership facts

Whether you're just starting medical school, maintaining a full-time practice, or retiring, SMS has a membership classification to fit your individual needs. Election to membership by the County Medical Society in which your principal place of practice is located carries with it membership in the State Medical Society of Wisconsin and, if you wish, the American Medical Association. If you qualify for resident membership at the time of your election, your membership dues are greatly reduced. This may also qualify you for reduced dues the first two years of your practice. In addition, two-physician families may be eligible for a $50 discount on total SMS membership dues. Dues for regular membership in 1988 are $480 for SMS, $375 for AMA, and county society dues vary. A more detailed listing of SMS membership classifications and their corresponding dues follows:

State Medical Society of Wisconsin

DESCRIPTION OF MEMBERSHIP CLASSIFICATIONS

Regular: Member in active practice. • ***First year in practice***—physicians elected to SMS membership within six months of completing residency, fellowship, or fulfillment of government obligation enjoy a dues reduction of 50 percent for the first year. • ***Second year in practice***—physicians who quality by meeting the above criteria enjoy a 25 percent dues reduction during their second year of practice. • ***Two-physician family***—one member (spouse) of a two-physician family is entitled to a dues reduction of $50 or the amount of their State Society dues whichever is less.

Resident: Physician who at January 1 of dues year is in an approved training program as a hospital resident or research fellow who is licensed to practice medicine and surgery in Wisconsin.

Military Service: Members who are serving in the U.S. armed forces or Public Health Service (generally not to exceed five years).

Associate: Member whose dues are waived because of financial hardship due to illness or disability. This classification is temporary and is reviewed on an annual basis.

Life: Member who has held membership in a state medical society for 50 years or is a Past President of the State Medical Society of Wisconsin.

Honorary: Member who was named by the Board of Directors in recognition of long and distinguished service to the cause of medicine.

Retired: Member who has completely retired from practice (works less than 240 hours per year). All dues are waived unless county society indicates they wish to charge county dues.

Part-time Practice: Physician, regardless of age, who practices 1,000 hours or less during the calendar year but does not qualify for retired membership.

Over Age 70: Member in active practice who is over 70 years of age as of January 1.

Candidate: Member attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure.

Scientific Fellow: The Board of Directors may by invitation and unanimous consent confer upon any person engaged in teaching of or research in one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy, the status of Scientific Fellow.

Emeritus: Retired members who have chosen not to renew their license.

1988 DUES AMOUNTS FOR THESE CLASSIFICATIONS

	SMS	AMA	COUNTY
Regular	$480.00	$375.00	Normal County Dues
1st Year in Practice	$240.00	$187.00	Normal County Dues
2nd Year in Practice	$360.00	$281.00	Normal County Dues
Two Physician Family	$430.00	$375.00	Normal County Dues
Part-Time Practice	$240.00	$375.00/-0-	Normal County Dues
Part-Time—Over Age 70	$240.00	$187.00*	Normal County Dues
Resident	$ 48.00	$ 45.00	Varies
Military Service	-0-	$250.00/$45.00	-0-
Associate	-0-	-0-	-0-
Retired	-0-	$375/$75/-0-*	-0-
Retired—Over Age 70	-0-	-0-	-0-
Life	-0-	$375.00/-0-*	-0-
Honorary	-0-	$375.00/-0-*	-0-
Over Age 70	$240.00	$375.00/-0-*	Normal County Dues
Candidate—			
Student	[1]$ 10.00	[2]$ 20.00	-0-
Postgraduate—One	$ 10.00	$ 45.00	Varies
Scientific Fellow	-0-	-0-	-0-
Emeritus	-0-	-0-	-0-

[1]Students' SMS and County Dues for four academic years.
[2]Students' AMA Dues for the calendar year 1988

*Physicians in these categories may be eligible for exemption from paying AMA dues under the grandfather clause

AMA dues-exempt members who were granted exemption before 1986 based on previously established criteria with the exception of financial hardship or disability will automatically be dues-exempt in 1986 and beyond under the grandfather clause

Under new AMA policy, only the following two categories of physicians will qualify for new dues exemption:
(1) Financial hardship and/or disability
(2) 70 years of age or older *and* fully retired

Under age 70 and fully retired AMA dues may be reduced to $75.00

Your membership in organized medicine . . .

. . . will help ensure the continued "safety" of your practice and quality care for all patients. Your voice *will* be heard through participation. Membership in the State Medical Society of Wisconsin also requires membership in the county medical society (AMA membership is optional but encouraged). For Regular, Part-time Practice, or Over Age 70 membership classifications, dues may be paid in one lump sum or in two equal installments: one-half of the total payable by January 1, the other half not later than May 15, 1988 which is the removal date for those members who have not completed payment. You are urged to renew your membership.

State Society dues are prorated on a monthly basis for those elected to membership July 1 through September 30. Those elected after September 30 have no dues payable for the balance of the year in which they are elected. AMA dues follow the same pattern except prorating is on a semiannual basis rather than monthly basis.

To begin the membership process, if your practice is or will be located in Wisconsin, or you have any questions, you may contact your local county society or call the Membership and Communications Division of the State Medical Society, if in Wisconsin: 1-800-362-9080 (Madison area number: 257-6781).■

PHYSICIANS EXCHANGE

Several Emergency Physicians, Board-certified/eligible, are needed to staff Level II Emergency Department with annual volume of 30,000 plus, July 1, 1988. Residents rotate through department making excellent teaching opportunity. Compensation package exceeds 120,000/yr. Flexible scheduling, 36 hr/wk, 1656 hr/yr. Partnership available in one year. Contact Sunil K Ahuja, MD, FACEP, Medical Director, Emergency Services at Sinai-Samaritan Medical Center, 2000 W Kilbourn Ave, Milwaukee, WI 53233; ph 414/937-5989. p3-4/88

Family Practitioner to associate with a highly successful two physician (one physician near retirement) rural family health center with an excellent support staff and unlimited potential. Complete fee-for-service practice with excellent hospitals and specialty support only minutes away. Guaranteed salary, incentives and benefits tailored to fit your needs. Located 15 minutes from a major metropolitan area and 30 minutes from the joys of Door County. Interested physicians please contact J C Majeski, Clinic Mgr, Luxemburg Medical Clinic, PO Box C, Luxenburg, WI 54217; ph 414/845-2351. p3-5/88

Rheumatologist—the Racine Medical Clinic a 34-physician multispecialty group conveniently located between Chicago and Milwaukee. Well equipped clinic offering salary guarantee with incentive bonus; excellent fringe benefits and early ownership. Please send curriculum vitae to: R D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 11tfn/87

BC/BE General Internist to join 26-MD multispecialty group with four internists, one nephrologist and one gastroenterologist. Top salary first year, full incentive thereafter. Central Wisconsin university town with drawing area of 80,000. Send CV to Dr John Gauder, Rice Clinic, SC, 2501 Main St, Stevens Point, WI 54481, or call collect 715/344-4120. 12tfn/87

RATES: 50¢ per word, with a minimum charge of $20.00 per ad. BOXED AD RATES: $25.00 per column inch. *All ads must be prepaid.*

DEADLINE: Copy must be received by the 15th of the month preceding month of issue; *eg,* copy for the August issue is due July 15. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 1-800-362-9080.

Medical oncologist. Central Wisconsin community of 50K needs aggressive Board-eligible/certified physician with entrepreneurial skills to develop market of 200K with one other medical oncologist. Compensation/benefits package with minimum salary of $130K plus 100% of collections after expenses and office space. Contact Bob Sweat, Tyler & Company, 9040 Roswell Rd, Atlanta, GA 30350. Call 404/641-6411. n/c3/88

Internist. Excellent opportunity for BC/BE internist(s). Integrated health system in fast growing desert community. Thirty-five minutes from Palm Springs. Compensation plan which includes high guaranteed base and incentive component. Send CV to Delta Hi-Desert Medical Group, 915 Camino Del Mar, Del Mar, CA 92014. 3/88

OB/GYN, Board-certified or eligible, to join highly progressive, rapidly growing practice. Normal and high risk obstetrics emphasized along with highest levels of infertility care (microsurgery, GIFT, IVF, Laparoscopic Laser Surgery), as well as extensive gynecology and surgery practice. Easy lake country or Milwaukee suburban living. Salary and guarantees to meet your needs with opportunity for partnership in one year. Available July 1988, or earlier. Contact Matt Meyer, MD, Women's Health Care, SC, Milwaukee Regional Fertility Center, 426 W Main St, Waukesha, WI 53186; ph 414/549-1333. 3-5/88

Pediatrics—Marshfield Clinic, a 250-physician multispecialty private group practice, is seeking a Board-certified or eligible general pediatrician to join its expanding regional center in Chippewa Falls. Chippewa Falls is a community of 15,000 people located in beautiful west central Wisconsin with a wide range of recreational, educational, and cultural opportunities easily accessible. The clinic is adjacent to a 110-bed JCAH accredited hospital. Competitive salary and fringe benefit package. Send curriculum vitae and references to Mr David Draves, Director, Regional Development, Marshfield Clinic, 1000 North Oak Ave, Marshfield, WI 54449 or you may call collect at 715/387-5376. 3/88

General Surgeon. Board-certified general surgeon needed to join expanding 85-physician multispecialty medical center in Los Angeles and Orange counties. An exceptional base salary and incentive plan. Benefits include malpractice insurance, group health and life insurance. Please send CV to Dept 604 in care of the Journal. 12/87;1-2/88

Physicians needed full- or part-time to perform light physicals. Milwaukee area. Professional liability provided. Phone 414/344-2100, Ms Jenkins. 10tfn/84

Primary Care Physician—Family Practice, General Practice, or ER experience desirable, to staff urgent care clinic on part-time or full-time basis. Excellent opportunity including guaranteed salary, profit-sharing, excellent fringe benefits, and stockholdership. Send CV to Louis C Bernhardt, MD, Chairman, Recruiting Committee, Dean Medical Center, 1313 Fish Hatchery Rd, Madison, WI 53715. Equal Opportunity/Affirmative Action Employer. p2-3/88

Lucrative Practice Opportunity for all medical and surgical specialties: especially FP, Dermatology, EENT, Ortho, Radiology, Pathology, OB, General Surgeons, PAs, Nurse Practitioners, Independent or Group Practice. Full-time/part-time/once-a-week or "moonlight." Multiple investment opportunities available. All options open for your advantage. Also, excellent Tax Shelter opportunities in a major sports and recreational region for "visiting physicians." Accommodation provided. Visit/call Farukh Khan, MD, Golden Medical & Surgical Center, Elkins, WV 26241; ph 304/636-5426. 2-4/88

BC/BE General Surgeon. Outstanding opportunity for general surgeon to associate with two active internists in a friendly rural community in Northeastern Wisconsin near Green Bay. New clinic attached to a 55-bed community hospital. Excellent long-term growth potential. Send CV to Artwich Clinic, Ltd, 815 South Main St, Oconto Falls, Wis 54154. p2-4/88

BC/BE Internist. Outstanding opportunity for general internist to join two active internists in a busy practice of internal medicine in a friendly rural community in Northeastern Wisconsin near Green Bay. New clinic attached to a 55-bed community hospital with new ICU/CCU. Excellent long-term growth potential. Send CV to Artwich Clinic, Ltd, 815 South Main St, Oconto Falls, Wis 54154. p2-4/88

Family Practitioner. Clinic seeking a well-rounded physician to practice at a growing established satellite clinic 30 miles north of main clinic. Clinic located in a friendly rural community with year-round outdoor activities. Send CV to Artwich Clinic, Ltd, 815 South Main, Oconto Falls, Wis 54154. p2-4/88

Urologist physician Board-certified/Board-eligible to join 23-physician multispecialty group in Winona, Minnesota. Total draw area of 40,000 population. Competitive salary offered. Interested physicians please contact J B Knuesel, Administrator, Winona Clinic, Ltd, 420 East Sarnia, Winona, MN 55987. 2-4/88

PHYSICIANS EXCHANGE

continued

Green Bay, Wisconsin. Twenty-eight physician multispecialty group seeking BC/BE physicians in the following specialties: Family Practice, Pulmonology, Pediatrics, ENT, and Anesthesiology. Green Bay is a progressive community with an easy lifestyle, ample outdoor activities, excellent schools and cultural activities. The Clinic offers competitive salary and excellent fringe benefits. Please send CV to: P M Kindrachuk, Administrator, West Side Clinic, sc, Post Office Box 19070, Green Bay, WI 54307-9070. 12/87;1-3/88

Primary Care Physicians—Family Practice, General Practice, or ER experience desirable. To staff clinics for industrial, walk-in, after hours, and satellite medicine. Excellent opportunity—guaranteed salary, profit-sharing, great fringes. Send CV to Administrator, Manitowoc Clinic, PO Box 3008, Manitowoc, WI 54220. p7-12/87; 1-5/88

Internal Medicine physician Board-certified/Board-eligible to join 23-physician multispecialty group in Winona, Minnesota, with existing nine-physician Internal Medicine Department. Total draw of 40,000 population. Competitive salary offered. Interested physicians please contact J B Knuesel, Administrator, Winona Clinic, Ltd, 420 East Sarnia, Winona, MN 55987. 2-4/88

GROUP HEALTH INC.

The physicians on staff at Group Health, Inc. comprise one of the oldest and largest multi-specialty group practices in the Midwest. Group Health, Inc. is primarily a staff model HMO, with affiliations with a number of respected medical groups and referral specialists throughout the Twin Cities area.

If you are board certified, or board eligible, in any of the following specialties, Group Health, Inc. may have an opportunity for you.

- Adult Psychiatry
- Cardiology
- Dermatology
- Family Practice
- Internal Medicine
- Obstetrics & Gynecology
- Ophthalmology
- Pediatrics
- Urology

For information about joining the Group Health, Inc. medical staff, call Jerry Hess at **(612) 623-8444.**

Group Health, Inc.
2829 University Avenue S.E.
Minneapolis, Minnesota 55414
3-6/88

Pediatrician to join existing two-person practice at the 23-physician multispecialty Winona Clinic, Ltd, in Winona, Minnesota. Located in the beautiful Mississippi River Valley of southeast Minnesota. The community with a 40,000 population trade area is the host of three colleges and a diverse industrial base. Send CV to J B Knuesel, Administrator, Winona Clinic, Ltd, 420 East Sarnia, Winona, MN 55987. 2-4/88

Internal Medicine. Board-certified or eligible to join four general internists in a multispecialty group in northeastern Wisconsin. Office is next to two hospitals. Partnership is available after one year. Send CV to Dept 596 in care of the Journal. p8-12/87; 1/88; 2-4/88

Family Practice—Madison, Wisconsin. Eleven-year-old staff model HMO has a family practice position available. We offer a very attractive practice setting with reasonable scheduling, excellent salary and benefits. Contact: John Hansen, MD, Medical Director, Group Health Cooperative, One South Park, Madison, WI 53715; ph 608/257-9700. 1-3/88

Wisconsin. OB/GYN (BC/BE) needed to join dynamic HMO-based multispecialty group practice. University town of 55,000 near Minneapolis. Community and recreation outstanding. Competitive salary and fringes. We take pride in our patient care. Contact: Robert A Braastad, MD, Group Health Cooperative, 1030 Regis Court, Eau Claire, WI 54701; ph 715/836-8552. p12/87;1-4/88

Primary Care. Primary care physician to work in "Walk-In" Department of 24-physician multispecialty clinic. 12 to 15 hours per week. Excellent back-up services. Complete lab and x-ray on-site. Lodging accommodations available. Contact: Administrator, Rice Clinic, 2501 Main St, Stevens Point, WI 54481 or call collect 715/344-4120. 6tfn/87

NEW PHYSICIANS FOR WISCONSIN
is seeking
• Family Physicians • Pediatricians
• Orthopedic Surgeons • Internists
Contact: Fred Moskol
UW Office of Rural Health
810 University Bay Drive
Madison, WI 53705
608/263-7933
7-12/87; 1-6/88

Beloit Clinic, SC, an expanding multispecialty group in a southern Wisconsin college town is seeking an internist, pediatrician, and family practitioner for second satellite clinic; and an additional BC/BE cardiologist and BC/BE neurologist for main facility. Guaranteed salary with incentive plus excellent fringe benefits. Send CV to James F Ruethling, Administrator, Beloit Clinic, SC, 1905 Huebbe Parkway, Beloit, WI 53511; ph 608/364-2200. 6tfn/87

West Bend, Wisconsin, General Clinic, a 20-physician multispecialty group is seeking additional B/C, B/E physicians in **Family Practice, Pediatrics, OB/GYN, Internal Medicine, Urology, Dermatology,** and ENT. First-year salary and benefits guaranteed. Corporate association after one year. Located in a family-oriented, economically strong small city surrounded by four-season recreational and scenic Kettle Moraine area 30 miles north of metropolitan Milwaukee. Contact Hans W Schmelzling, Administrator, 279 S 17th Ave, West Bend, WI 53095; ph 414/338-1123. 7tfn/87

Excellent opportunity for a Board certified or eligible **ob/gyn** to practice in conjunction with a 4-member OB/GYN Department of a 28-member multispecialty group. The group is located in southeastern Wisconsin, in a city of 100,000 between two major metropolitan areas. If interested, please send CV to: William H Olson, Kurten Medical Group, 2405 Northwestern Ave, Racine, WI 53404. All inquiries will be kept confidential. 5tfn/86; c1tfn/88

Orthopedic Surgeon. Board-certified/Board-eligible to join a 23-physician multispecialty group in Winona, Minnesota. Total patient population draw area of 40,000. Interested physicians please contact J B Knuesel, Administrator, Winona Clinic, Ltd, 420 East Sarnia, Winona, MN 55987. 2-4/88

Position Available. Industrial Medicine Group seeking 4 physicians interested in practicing comprehensive healthcare in a stable correctional health setting. Enjoy the full spectrum of general medicine in a protected environment. Quiescent rural and cultural urban positions available. Controlled hours and administrative duties. Liberal salary and benefits. For further information please send current CV to M Sorenson, Westmound Clinics, 683 Westmound Dr, Waukesha, WI 53186; ph 414/544-1300. 2-3/88

Twenty-nine physician multispecialty clinic located in desirable East Central Wisconsin location is seeking Board-certified or Board-qualified orthopedic surgeon to round out its services. Lab, x-ray, excellent hospital. Liberal guarantee and benefits. If interested contact D F Sweet, MD, Fond du Lac Clinic, SC, 80 Sheboygan St, Fond du Lac, WI 54935. 9tfn/87

Eagle River—Great opportunity for two BC/BE family practice physicians to join well-established practice. Guaranteed annual income and future partnership available. For more information, send resume to Judy Harris, Recruiter, UW Office of Rural Health, 810 University Bay Dr, Madison, WI 53705 or call collect 608/263-7933. 1tfn/88

MEDICAL FACILITIES

For Sale. Gemstar Chemistry Analyzer, Starlyte 1, Centrifuge, Cell Trak 3-B Cell Counter, Coagulation Unimeter, Burdick EKG, Hamilton Image Table, Welch Allyn Sigmoidescope, Bennett X-ray machine and processor, autoclave and many instruments and other office supplies. All about three years old and in excellent condition. Contact Peninsula Health Care, 325 N Third Ave, Sturgeon Bay, WI 54235. 3/88

Milwaukee, Wisconsin suburban practices for sale. Primary care full practice opportunity. Hospital area. Retiring general internists. Can accommodate 1-3 physicians. Will introduce. Financial assistance available. Submit CV to PO Box 27622, Milwaukee, WI 53227. 2-3/88

MISCELLANEOUS

HOLTER MONITOR
Quality Scanning for reel or cassette type recorders by qualified technicians and certified cardiologists' interpretations, scan price $35.00 with UPS speedy delivery. Recorders loaned, leased, or purchase new dual-channel Holter recorders, $750.00, with two-year warranty. For more information call Advance Medical and Research Center 1-800/552-6753. 11tfn/85

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

WISCONSIN

MARCH 23, 1988: *Islet Transplantation.* American Diabetes Association/Wisconsin Affiliate, Inc. Guest lecture. Time: 8:00 pm at Performing Arts Center, Milwaukee. Info: 414/464-9395. p3/88

APRIL 8, 1988: *On the Cutting Edge,* sponsored by the State Medical Society of Wisconsin and the Wisconsin Hospital Association at MECCA in Milwaukee. Info: SMS Division of Communications, ph 608/257-6781 or toll-free 1-800/362-9080 in Wisconsin. g3/88

APRIL 8, 1988: *Fourth Annual Duluth Heart Conference.* Sponsored by The Duluth Clinic, Ltd, and St Mary's Medical Center. Credits: AMA Category I, 6 hours; AAFP prescribed, 6 hours. Info: Barb Jablonski, Duluth Clinic Administration, 400 East Third St, Duluth, MN 55805; ph 218/722-8364, ext 710. 1-3/88

APRIL 22, 1988: *Wisconsin Chapter-American Academy of Pediatrics* Annual Meeting, at the American Club, Kohler. Theme: "Renal diseases: A Wisconsin perspective on hypertension, hemolytic uremic syndrome, and primary care concerns." Contact Carl Eisenberg, MD: 414/352-3100. g11-12/87; 1-3/88

APRIL 26, 1988: *Wisconsin Academy of Ophthalmology,* held in conjunction with the Milwaukee Opthalmic Society meeting, University Club, Milwaukee. Info: 414/259-1930 (Arleen). g1-3/88

APRIL 28-30, 1988: State Medical Society of Wisconsin Annual Meeting, Milwaukee.

MAY 13-14, 1988: *Moving Over or Moving Out: The Older Health Care Professional Deals With the Present and the Future.* Seminar for the older health care professional who, in dealing with the changes in the system, is considering career options *vs* adjustment will be presented on Friday evening, May 13, and Saturday, May 14 at the Olympia Village Conference Center, Oconomowoc. Topics include identifying the problem and its effects on the individual and relationships, ethical dilemmas, and decision making. This seminar is being co-sponsored by Bellin Hospital, Green Bay, and the Howard Young Medical Center, Woodruff, in cooperation with the Medical College of Wisconsin, Milwaukee. Info: call 414/433-7815. p3-4/88

State Medical Society of Wisconsin

Dates and locations of ANNUAL MEETINGS 1988-1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel, unless otherwise indicated.

1988—April 28-30
1989—April 13-15
1990—April 26-28: ***Green Bay***
Convention Center, Embassy Suites
1991—April 18-20
1992—April 23-25

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

JUNE 2, 1988: *Gastroenterology for the Practicing Physician* at Red Carpet Hotel/Airport, 4747 South Howell Ave, Milwaukee. Sponsored by The Center for Digestive Disorders at Trinity Memorial Hospital, and Merck, Sharp & Dohme Pharmaceuticals. 9:30 am-3:30 pm. Lunch provided. No charge. Course director, Joseph E Geenen, MD. Info: James G Streed, Trinity Memorial Hospital, 5900 South Lake Dr, Cudahy, WI 53110; ph 414/769-4050. g2tfn/88*

JUNE 3-4, 1988: Wisconsin Radiological Society and the Milwaukee Roentgen Ray Society, American Club, Kohler. g11-12/87;1-5/88

JUNE 16-19, 1988: Wisconsin Academy of Family Physicians, Holiday Inn, Stevens Point. g10tfn/87

JULY 21-23, 1988: *Wisconsin Society of Obstetrics and Gynecology,* Landmark Resort, Egg Harbor. g1-6/88

JULY 29-31, 1988: Wisconsin Dermatological American Club, Kohler. 12tfn/87

AUGUST 3-8, 1988: *"International Doctors In Alcoholics Anonymous,* Stouffer Hotel, Baltimore, MD. Info: Information Secretary, IDAA, 1950 Volney Rd, Youngstown, OH 44511; ph 216/782-6216. g1-7/88

SEPT 9-11, 1988: Wisconsin Society of Anesthesiologists, Convention Center/Embassy Suites, Green Bay. g10tfn/87

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 50¢ per word, with a minimum charge of $20.00 per listing. *All listings must be prepaid.*

BOXED LISTINGS: $25.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 15th of the month preceding the month of publication: *eg,* copy for the August issue is due by July 15. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 1-800-362-9080.

FOR LISTING of other meetings see the January 1, 1988 issue of the *Journal of the American Medical Association:* Continuing Education Opportunities for Physicians for period March 1988 through August 1988.

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

continued

OCTOBER 20–21, 1988: Wisconsin Chapter, American College of Emergency Physicians, The Abbey, Lake Geneva. 2tfn/88

AMA

JUNE 26–30, 1988: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 4–7, 1988: Interim House of Delegates, Dallas, TX.

JUNE 18–22, 1989: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 3–6, 1989: Interim House of Delegates, Honolulu, HI.

JUNE 24–28, 1990: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 2–5, 1990: Interim House of Delegates, Orlando, FL.■

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SMS Services, Inc 35
United Credit Service . . . . . 60■

Medicaid and Medicare seminars

You can still register for the full-day Medicare seminars with presentations by WPS staff. The cost is $40 per person, which includes refreshments, lunch and a comprehensive educational manual. To attend, please complete the attached registration form.

Registration form (please print)—**Return with your check payable to: State Medical Society, P.O. Box 1109, Madison, WI 53701.**

Name _____

Title _____

Clinic/Organization _____

Address _____

_____

City State Zip

Telephone ( ) _____

Is your physician an SMS Member? ____ Yes ____ No

Please check the seminar you are interested in:

		(Check 1 Session) Morning	Afternoon
____ **Medicaid Seminar ($21 per person)**			
Madison (East Towne Holiday Inn)	April 12	_____	_____
Green Bay (Embassy Suites)	April 14	_____	_____
Milwaukee (Sheraton North)	April 19	_____	_____
Milwaukee (Airport Ramada Inn)	April 20	_____	_____
Cable (Telemark Lodge)	May 4	_____	_____
Eau Claire (Civic Center Inn)	May 5	_____	_____
____ **Medicare Seminar ($40 per person)**			
____ Lake Geneva (The Abbey)	March 23		
____ Stevens Point (Holiday Inn)	March 25		

Wisconsin Specialty Society Meetings 1988

- Wisconsin Chapter-American Academy of Pediatrics Annual Meeting, American Club, Kohler, April 22, 1988.
- Wisconsin Radiological Society and the Milwaukee Roentgen Ray Society, June 3–4, 1988, American Club, Kohler.
- Wisconsin Academy of Family Physicians, June 16–19, 1988, Holiday Inn, Stevens Point.
- Wisconsin Society of Obstetrics and Gynecology, July 21–23, 1988, Landmark Resort, Egg Harbor.
- Wisconsin Society of Anesthesiologists, Sept 9–11, 1988, Convention Center/Embassy Suites, Green Bay.
- Wisconsin Society of Internal Medicine, Sept 15–17, 1988, Milwaukee Marriott.
- Wisconsin Radiological Society, Sept 30–Oct 1, 1988, Concourse Hotel, Madison.

* * *

Specialty Society Meetings to be held in conjunction with SMS Annual Meeting, April 28–30, 1988, Milwaukee

- Wisconsin Allergy Society
- Wisconsin Society of Anesthesiologists
- Wisconsin Chapter, American College of Emergency Physicians.
- Wisconsin Academy of Family Physicians
- Wisconsin Society of Pathologists
- Wisconsin Society of Physical Medicine and Rehabilitation
- Wisconsin Society of Radiation Oncologists

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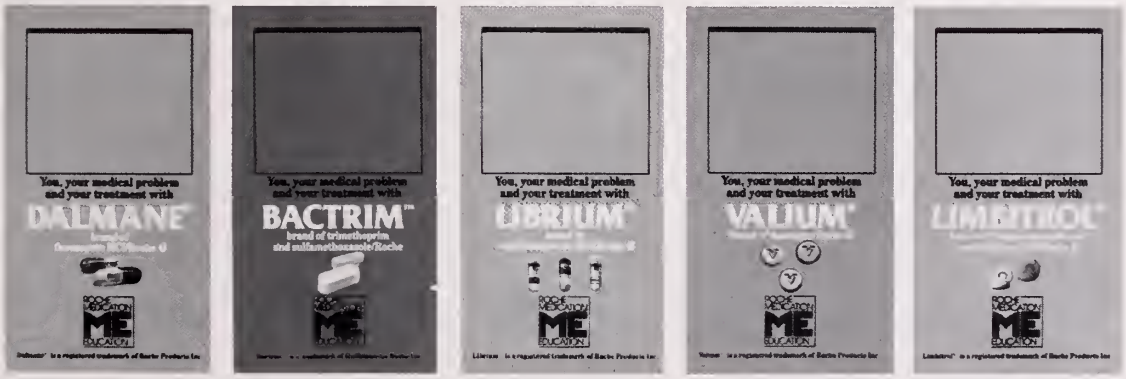

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WISCONSIN MEDICAL JOURNAL

Resource-Based Relative Value Scale . . . Secretary-General Manager Tom Adams takes a look at the latest Medicare physician reimbursement plan: "We must avoid jumping to conclusions or acting on the basis of rumor" (see page 7).

Medicine in the good old days . . . A survey of Wisconsin physicians over age 60 provides a window to the past (see page 13).

Loss Prevention Corner . . . The Wisconsin Medical Journal begins a socioeconomic series seeking to apply preventive medicine to the professional liability crisis (see page 36).

House of Delegates . . . 35 resolutions to be considered by the House when it convenes at the SMS Annual Meeting, April 28–30, are summarized (see page 42).

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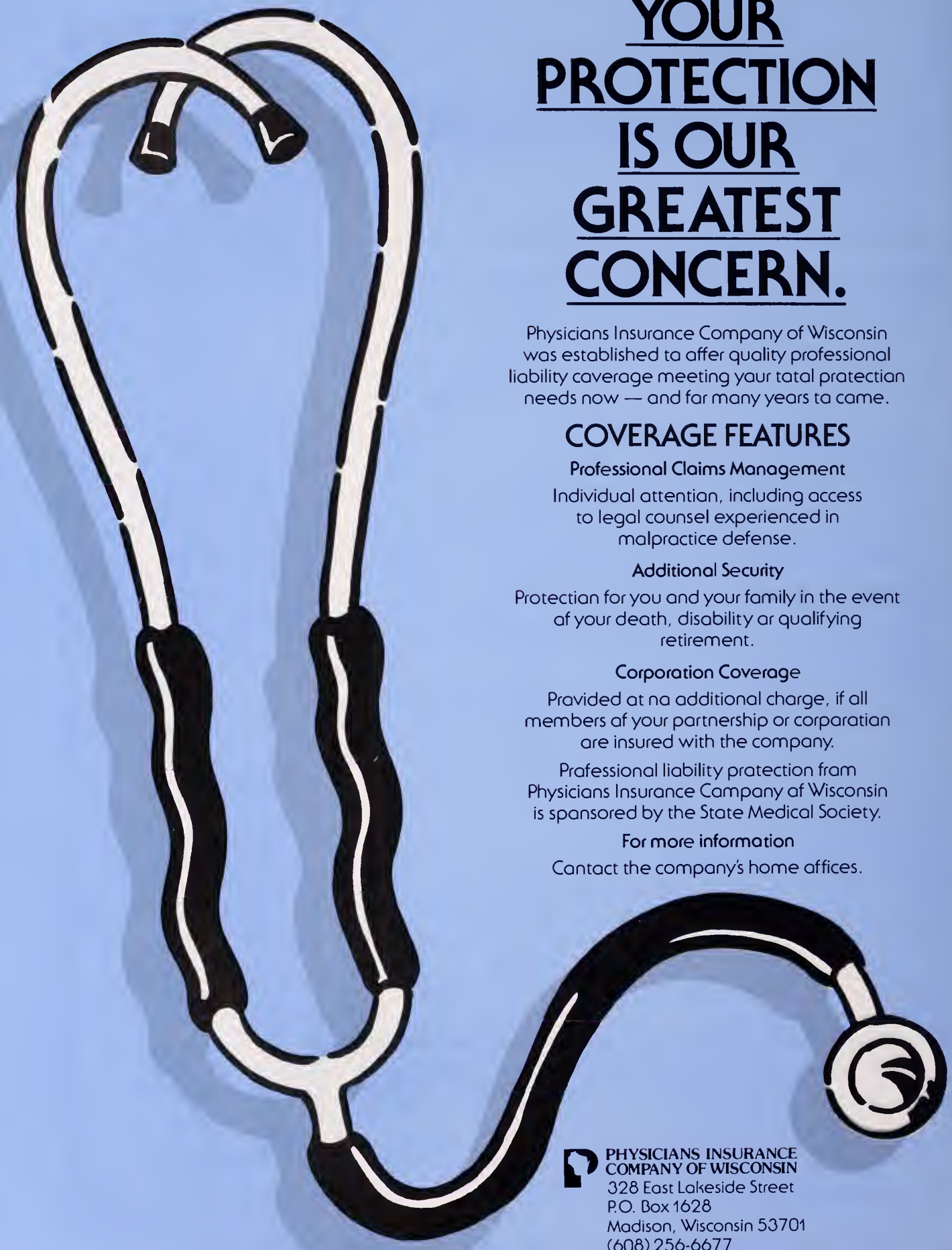

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Kenneth M Viste Jr, MD

Standard setting: the next challenge

SETTING STANDARDS for measuring the quality of health care is one of the major challenges for the profession during the next decade. Purchasers of health care—private citizens, governments and businesses—are increasingly concerned about value as well as cost. They want proof of quality not unlike what they expect from other products and services. As physicians, we should be attentive to the nature of the standards to assure that they are appropriate, that they promote better health care, and that they ensure patient safety.

Standard setting is not new to us. Physicians, more than any other profession, have set and applied standards for education, certification, licensure, and privilege delineation. Now, we are faced with setting standards for quality in the quality-cost equation.

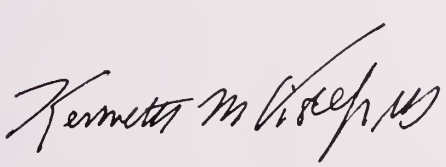
Massive quantities of statistics, which can be used in forming judgments about quality, are now available. The items studied are too often those that are easiest to measure, such as death or hospital length of stay, while equally important factors, such as patient satisfaction or understanding of their disease, are left out of the equation. Too many judgments are being made about standards of quality without adequate physician participation.

We physicians, of course, cannot be the sole arbiters of quality, but we certainly can take the lead in shaping the standards—often in competition with government, business and consumer groups, which will develop standards to serve their particular purposes.

Medicare has shifted from an initial emphasis on access to a later emphasis on cost, and now to what appears to be a dominant concern for quality. This coincides with activities of the specialty societies, which have been publishing standards of patient care, and the American College of Physicians, which recently issued a manual designed to enable physicians to avoid unnecessary diagnostic testing and make the best use of currently available tests by discussing costs as well as benefits.

There are, of course, legal risks—of both antitrust and professional liability—to the members of societies and organizations that publish standards. Fortunately, according to lawyers conversant in this area, when these activities are carried out *in good faith* the legal risk is relatively minor. There is also the danger that the result of publishing standards of quality will be a "cookbook" approach to medicine. Nevertheless, the public and the payors are increasing their demands for "proof of quality."

It is the duty of physicians to help shape the guidelines and standards that will define our practice in the future—and that will guide us toward an ever greater quality of practice.



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RBRVS = $(Ia_{ta} + Ib_{tb})(1 + AST)(1 + RPC)$

Thomas L Adams
Secretary-General Manager

EVERY YEAR since 1982 Congress has made piecemeal attempts to change physician reimbursement under Medicare, Part B. Those changes have ranged from two years of outright freezes on fees to the current participating/non participating/MAAC program which I can best categorize as an outright failure.

In 1987 alone the AMA defeated mandatory assignment four times, three times in the Ways and Means Committee and once in Energy and Commerce. The major reason for these successes was the 1985 Congressional directive to the Health Care Financing Administration (HCFA) to develop a Resource-Based Relative Value Scale (RBRVS) for physician reimbursement in Medicare for consideration by Congress. The RBRVS method measures physicians' resource costs—such as the time, effort and training their work demands and the overhead costs of practicing medicine—to construct relative values for the services and procedures of different specialties. It crosses interdisciplinary boundaries to create a single set of rankings, in nonmonetary units, for all.

To that end HCFA issued a request for proposals to develop an RBRVS in late 1985. The AMA, supported by the state medical societies, submitted a proposal to develop the RBRVS, but the proposal was eliminated from consideration due to federal antitrust concerns. Ultimately, HCFA awarded the contract to Harvard University, which named William C Hsiao, PhD, and Peter Braun, MD, to conduct the study. The AMA assisted in this study in the capacity of a subcontractor. The Harvard study includes two distinct phases—the technical stage and the consensus process. The technical aspects of the study have been reviewed in detail by expert AMA staff and physician technical consultants. The consensus process involved a panel that considered the broader issues of applying the RVS to physician reimbursement. The AMA has staff on the advisory committee and has a senior research investigator working on the planning and design of the study.

The study is now nearing completion and will be presented to HCFA in July. Under the authorizing legislation HCFA is then required to submit a plan to Congress to change physician reimbursement to an RVS-based system in January. Congress could implement the plan as early as January 1990. Will Congress automatically adopt the RVS methodology for physician reimbursement under Medicare Part B? Not necessarily.

Significant opposition to the RVS exists both among some of the Congressional leadership including Rep Dan Rostenkowski (D-Ill), Rep Pete Stark (D-Cal), and HCFA administration including William Roper, MD, HCFA's chief administrator. Their opposition stems from the fact that an RBRVS does nothing to limit the volume of service and is seen as not being a radical change to previously tried payment methodologies. An RVS based on physician charges was developed by the California Medical Society in the late 1960s and early 1970s. This fee schedule, along with other charge-based RVSs was widely used for physician payment until the US Justice Department halted their use as being anti-competitive in 1972–73. Only anesthesiology, which fought the government successfully in court, was able to retain and use an RVS.

Congress has made clear that it wants a physician payment system that 1) is predictable, 2) controls volume, and 3) offers beneficiary protection (read mandatory assignment). If the RBRVS appears to accomplish these three tasks, it is likely to be looked on favorably by Congress. If other reimbursement methodologies, such as capitation, vouchers, etc. appear to better accomplish those goals, then Congress will be less likely to adopt the RVS.

On March 28 President Viste and I attended a briefing in Chicago by the senior staff and officers of the AMA on the progress of the RVS development. Several points were made that we should remember as debate on the RVS occurs over the next few months.

- The RVS is being developed by Harvard, not the AMA. The AMA has not committed itself to supporting the final RVS results.
- State medical societies may support or oppose use of the RVS as we find appropriate.
- Computer models will be run by AMA to assess the impact of the RVS on the various specialties for presentation to the House of Delegates.
- AMA staff and individual specialties have been involved as consultants during the developmental stage of the study.

Between August and the AMA Interim Meeting in December, SMS will very thoroughly review the impact of the RVS on Wisconsin. Doctor DeLore Williams, chairman of the SMS delegation to the AMA, has indicated that the Wisconsin delegation will undertake an effort to explain the RVS at county medical societies and hospital medical staff meetings around the state.

It is critical in those months, while consensus is being developed throughout the country, that the profession speak with one voice on the issues relating to RVS. For one specialty to try to "negotiate" separately from AMA with the Congress could well spell catastrophe for organized medicine. It was exactly such separate negotiations that weakened organized medicine in Great Britain thus allowing the nation to slip into national health insurance. Today that system consists of intolerable delays for care and poor facilities and is near bankruptcy.

By December we must reach a consensus. The State Medical Society will do its best to facilitate debate and provide you with accurate information. We must avoid jumping to conclusions or acting on the basis of rumor. I have assigned Ms Patricia Ramsay in the Division of Medical Policy and Practice to be the staff issue manager on RVS. If you have questions or need clarification of issues, please call Trish or any member of the AMA delegation. ■

Unsigned editorials express views consistent with the policies of the State Medical Society of Wisconsin. Signed editorials express personal views of the author for which the Society takes no responsibility.

A threat to biomedical research

Physicians and the public should be alerted to the threat to biomedical research which exists in our society. The antivivisectionists and animal rights activists are having a serious impact on the way biomedical research in this country and around the world is conducted. These groups are extremely well funded, highly organized, nationally orchestrated, and very effective at achieving their goals.

It is rather frightening to learn of the extremes to which opponents of animal experimentation will go. In an article which appeared in *U.S. News and World Report* (Aug 31, 1987), the militancy of the animal rights activists was documented. A farm animal diagnostic laboratory under construction at the University of California-Davis was set on fire. Cost: $3.5 million. The Yerkes Regional Primate Center in Atlanta was hit with bomb threats and attempted break-ins. Cost: more than $200,000 in new security. Hundreds of research animals were stolen and equipment was smashed at the University of California-Riverside. Cost: more than $600,000 and years lost in a study of surgery to correct vision defects in infants. And the list goes on.

While such gross intimidation has not raised its ugly head in Wisconsin as yet, we should be aware that animal rights activists are being organized here. Evidence of this activity was seen in Racine County last year with regard to restricting the sale of dogs to the Medical College of Wisconsin for biomedical research. The goals of the animal rights activists will be to introduce bills in the Legislature to protect the so-called

rights of animals—the ultimate effect of which will be to restrict biomedical research.

To counteract these efforts, it is incumbent upon physicians, the State Medical Society, and medical research institutions to become informed of these misguided efforts of the animal rights activists. We must gird ourselves for the battle which is sure to come in due course. It is important for all county medical societies to become involved with these threats to biomedical research and lend their voices in opposition to the animal rights activists. It is our duty to speak out in defense of biomedical research and its inestimable benefit for the good of mankind.

To give form and substance to the defense of biomedical research, the Wisconsin Association for Biomedical Research and Education (WABRE) has recently been formed. Members of its board of directors come from the Medical College of Wisconsin, Marquette University, the University of Wisconsin-Madison, the University of Wisconsin Animal Care Unit, and the University of Wisconsin Medical School. Under the dynamic leadership of its president, Allen W Cowley, professor and chairman of the Department of Physiology at the Medical College of Wisconsin, WABRE will serve as an educational and research group for Wisconsin in regard to biomedical research and the threats to its existence. This association deserves our support and encouragement, for upon its success depends the continued benefit to our patients of the fruits of present and future biomedical research. (For further information, write to WABRE, PO Box 26505, Milwaukee, WI 53226.)

—*John P Mullooly, MD,* Milwaukee

LETTERS

The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

What shall we do?

TO THE EDITOR: At 3 AM on January 14, 1986, Bill awoke with an urge to urinate, but the pain in his neck was so severe that he could not even raise his head. His wife tried to raise his head but the pain in Bill's neck was much too severe. The problem was finally resolved by fastening a sheet about a doorknob. While his wife supported his head and shoulders, Bill pulled on the sheet and, in agony, pulled himself into a sitting position.

Both sat on the edge of the bed, concerned and a bit frightened. Bill's neck and upper back seemed on fire. They asked each other the same question, "What shall we do?"

Several days before, on the way to Florida, Bill had spasms in his neck and left shoulder, with some pain radiating down his left arm. Bill first relieved them with analgesics, but when the pain became worse he had called his son, Mark, an orthopedic surgeon in West Allis, Wis, who suggested neck traction. This was attempted but soon abandoned, because it aggravated the pain. Hot packs and percodan were suggested, and these gave modest relief.

"What shall we do?" the 75-year-old, semi-retired physician asked again. He was a large man, 6 ft 4 in and 240 lbs—a big problem for his small wife.

"Shall we call an ambulance and go to a local hospital?" his wife asked.

"If we do, the attending doctor will have to start from scratch," Bill said. "He won't know that I have had multiple epidural steroid injections for shooting pains in my left leg. He won't know about the arthritic changes in my spine."

"Yes," his wife said. "I recall that the neurosurgeon in West Allis said you have the worst spinal arthritic changes he had ever seen."

Bill said, "You know, I haven't wanted to worry you, Dear, but you recall that five years ago I had surgery for colon cancer. Sometimes it spreads to the bones. Olson and McIntyre, patients of mine, had just such metastases this last year. Eight years ago, I had prostatic surgery. It appeared benign, but unrecognized malignancy of the prostate is common and spreads to the bones. These must be considered, although I still think my neck and shoulder pains are due to bony outgrowths encroaching on nerves."

"Well, maybe we should go back to Wisconsin where the doctors know your case. But we just got here two days ago. What will we do with our car? We can't drive back. We will have to fly," Bill's wife said without enthusiasm.

Bill said, "Let's get our friend, Charlie, to take us to the airport—if we can get a flight. It's going to be a difficult trip on both of us. Are you up to it?"

"I think so. How about you?" she asked.

"I'm a patient now and I'd feel more comfortable with doctors who are well acquainted with my case. So, if you are willing, let's see if we can get plane reservations right away."

Yes, these two were 1400 miles from West Allis and uncertain what was best to do. Again Bill called his son, who urged them to fly to Milwaukee where he could meet them. Both the drive to the airport and the flight were painful. In spite of a shot of demoral and a cervical collar, the pains were severe. A necessary change of planes at Atlanta added to Bill's discomfort.

In Milwaukee, Mark decided to take his father to West Allis Memorial Hospital. "We will have to take tests to determine the cause of the problem," he said. "In fact, quite a few tests may be necessary, but

WHAT'S THE REAL "BOTTOM LINE?"

When health care leaders get together these days, the terminology seems considerably different than not so long ago. Without question, business terms have their place in health care today –terms like "trend correlation... segmentation... **bottom line.**"

But, when you need to refer your patient for psychiatric treatment, we thought you might like to know that somebody still remembers that the real "bottom line" is quality patient care.

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we'll have to ease the pain and spasms first."

An extra large bed was obtained, and various positions were tried until the least painful was found. Heat packs were applied to the neck, and narcotics were given. By the following morning, the intensity of the pain had diminished sufficiently to take X-rays of the cervical and thoracic vertebrae. These revealed marked spurring and that the sixth, seventh and eighth cervical vertebrae had fused spontaneously. However, efforts to take an electromyelogram had to be abandoned because of muscle spasms and pain.

Within three days the requisite tests were completed and peace of mind was obtained, for it was encroachment of bony tissue, not cancer, that was causing the pain. Bill was released from the hospital and advised to continue using aspirin as he had done for years for arthritic pain, and percodan for severe pain when necessary.

For several months, Bill's neck and shoulders bothered him, often waking him at night, but the need for restricted activity was equally annoying. The pains responded to frequent applications of hot packs but, although they subsided in intensity, they did not disappear. Bill often said, "You can get used to hanging if you have to."

One day, the mailman brought a message that seemed totally unfair—Medicare refused to pay the hospital bill, saying the tests could have been performed on an outpatient basis. And, of course, they could have *if* there had not been the pain to contend with. And the tests would have cost the same. But what individual, sitting in some Medicare office, could appreciate the true situation and properly determine that hospitalization was unnecessary. Wasn't this the rightful task of the physician in charge?

Yes, Bill is familiar with the problems of Medicare. He has practiced medicine and surgery in Wisconsin for more than 45 years. He knows that a small percentage of physicians have padded bills, creating a real problem for Medicare. But Medicare's refusal to pay, based on a perusal of medical forms by a nonmedical person flaunts the attending physician's word and will not remedy the problem of dishonest physicians.

After 45 years of medical experience, I feel compelled to voice my protest, for I am the Bill, the 75-year-old physician in this story.

—*William B A J Bauer, MD*
417 West Fourth Street
Ladysmith, WI 54848■

P.S. All the participants—the attending doctor, Bill's wife and the hospital administrator disagreed with WIPRO's determination and requested a reconsideration hearing. This was held on April 28, 1987, and the decision was reversed.

Editor's note: While the majority of the Editorial Board were agreeable to publication, there were comments worthy of

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being heard. One reviewer acknowledged our frustrations as physicians with an evergrowing bureaucracy. He felt publication of reports such as this serve only the purpose of ventilation. Another comment indicated that while there was great weeping and gnashing of teeth, in the final analysis the process worked in that rejection of payment was reversed by WIPRO reviewers.—RDS

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SMS Services, Inc has an agreement with Modern Business Machines in Madison to provide SMS members with a discount on IBM Actionwriter typewriters, IBM Wheelwriters 3 and 6, IBM Quietwriter 8, and the IBM Wheelwriter Systems 20 and 40.

For further information contact Noreen Krueger at SMS Offices in Madison at 608-257-6781 or 1-800-362-9080, extension 141.

Medical assistants

TO THE EDITOR: The American Association of Medical Assistants is the largest and oldest organization for health professionals. The Wisconsin Society of Medical Assistants is the state chapter of the national organization.

We'd like to urge physicians to encourage their medical assistants, office personnel and laboratory assistants to join the Wisconsin Society. Our members work in doctors' offices, hospitals and other medical facilities under the supervision of physicians. The Society's primary purpose is to provide continuing educational opportunities for personal and professional development.

There are several benefits of the organization, in addition to continuing education. Two educational seminars are held each year, one in the fall and the other in the spring. An annual meeting, usually held in May, includes an educational program in addition to the House of Delegates session and installation of officers' banquet.

The national organization publishes the bimonthly *The Professional Medical Assistant,* and offers a certification examination designed to evaluate competency. There is also a program for revalidation, which can be accomplished in two ways: take the test over, or use continuing education. Beginning this year, 1988, the CMAs will have to begin to revalidate to keep their certification.

For further information, physicians or their medical assistants may contact the Society president, Corinne Boushon, CMA, or the vice president and public relations chairman, Noreen Soeller, CMA, at 715-387-5190.

—*Noreen Soeller, CMA*

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"For an elegant night of Italian dining." —PROF HERBERT KUBLY, *Milwaukee Journal* writer

The Wisconsin Association of Senior Physicians was formed through the SMS in the early 1980s. The organization had a number of purposes, but was organized primarily to help overcome some of the abrupt and shocking changes many physicians face when they retire and to help them continue to be part of the advances of medicine.

With regard to advances in both diagnostic and therapeutic technologies, the twentieth century has been without a doubt the most exciting and rewarding. The members of this organization not only made this history, they are this history. When they are no longer here, much of the history will have gone with them.

It was suggested, therefore, that the members collect, contribute, assemble, and publish a comprehensive history of medicine as they practiced it. To begin, David L Schiedermayer, MD, Debora E Simpson, PhD, and I developed the first of a series of questionnaires designed to collect information on the members, their practices and their attitudes toward medicine as a profession.

This article, "A descriptive analysis of elderly Wisconsin physicians' practice satisfaction," has been developed through careful analysis of the information gathered, and is the first of a series of articles on "medicine in the good old days." We found the information fascinating, and we look forward to receiving additional data and ensuring that this history will not go unrecorded.

—*Kristin Bjurstrom Krueger, BA*
Director
Division of Foundation Activities■

SPECIAL

A descriptive analysis of elderly Wisconsin physicians' practice satisfaction

David L Schiedermayer, MD
Deborah E Simpson, PhD
Milwaukee, Wisconsin

Kristin Bjurstrom Krueger, BA
Madison, Wisconsin

ABSTRACT. *We surveyed 131 self-selected elderly Wisconsin physicians about their early years in practice. The purpose of the study was to determine which aspects of medical practice elderly physicians found particularly satisfying. The respondents were a geographically stable group who reported warm relationships with their patients and communities, and earned good livings despite spending a significant amount of time giving free medical care. The physicians favored specialization and technology, but disliked current trends toward increasing government and corporate intervention in medicine. They had fond memories of their practices of medicine.*

Since many of the physicians who practiced during the Depression are now quite elderly, we view the present as a unique window of opportunity for descriptive studies of their practices. For the past three years, we have been surveying groups of senior Wisconsin physicians about various topics. Next month, we will report on their medical and nonmedical moonlighting jobs.[1] In this report we present their recollections of their patients, incomes, charity care, community involvement, and overall satisfaction with medicine.

Methods. A three-page questionnaire was included in a mailing from the Wisconsin Association of Senior Physicians to all 1,240 Wisconsin physicians over age 60. The sample group was a small, self-selected subset (131 physicians) who were willing to complete the survey. The questions covered age, practice location, average income during the first 10 years in practice, number of years practiced, type of practice, call schedule, time spent in charity care, awards for community recognition, and levels of career satisfaction.

Medicine in the good old days

Physicians were asked to select the statement(s) which most accurately described their relationship with the majority of their patients (like family, friendly, acquainted, professional, unacquainted). They were also asked to pick from among similar terms those which they thought most of their patients would have selected to describe them.

Two open-ended questions provided respondents an opportunity to comment in detail on recent changes in medicine and the high points of their practices.

Doctor Schiedermayer is assistant professor, Division of General Internal Medicine, and associate director, Center for the Study of Bioethics, and Doctor Simpson is assistant professor of Family Medicine, both of the Medical College of Wisconsin, Milwaukee; Ms Bjurstrom Krueger is director of the Division of Foundation Activities of the State Medical Society of Wisconsin. This work was supported by a grant from the National Fund for Medical Education. Reprint requests to: David L Schiedermayer, MD, Center for the Study of Bioethics, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, Wis 53226 (phone 414/257-8498). Copyright 1988 by the State Medical Society of Wisconsin.

ACKNOWLEDGMENTS: The authors wish to thank the senior Wisconsin physicians who participated in this study, and Ms Colleen Berg for valuable assistance in manuscript preparation.

Results. The demographic characteristics of the respondents are shown in Table 1. Fifty-one (39%) were more than 73 years old. The mean number of years in practice was 40 ± 0.7. Forty-four (34%) practiced in their hometowns, and 113 (86%) currently reside where they practiced. Hometown practice was significantly more frequent ($p<0.05$) among non-World War II era physicians, but 80% of those physicians chose to reside in the town where they practiced.

The respondents' reported mean incomes during their first 10 years of practice are listed in Table 2. Fifteen observations are missing. The majority of physicians who began practice during the Depression made less than $7,500 per year, but so did the majority of the population during that era. When adjusted for changes in the Consumer Price Index, physicians during all three eras made salaries which would be in the $50,000-plus range today.

Those who began practice during the Depression or World War II were more likely to be generalists ($p<0.005$) than those who began after World War II.

Non-reimbursed care constituted less than 5% of the practice of 43 (33%) physicians, 5%-10% of the practice of 53 (40%), 11%-20% of the practice of 22 (17%), and more than 20% of the practice of 13 (10%). There were no statistically significant differences in the amount of charity care delivered by physicians of the different eras or by physicians who reported different salaries.

Physicians of all three eras reported they were "like family" or "friendly" with many of their patients, and there was no difference among the eras in the quality of the reported doctor-patient relationship. Eighty-three physicians reported receiving community awards or recognition for their service as physicians. Career satisfaction was higher among doctors who practiced in earlier eras; 36/41 of Depression and 29/30 of World War II era physicians reported being highly satisfied with their practices of medicine, but only 46/60 (77%) of those who began practice after World War II were highly satisfied ($p<0.05$). Table 3 lists some of the high points of the responding physicians' practices.

The respondents approved of the following changes in medicine: specialization 130/131 (99%), advanced technology 100/131 (76%) and third-party payment 83/131 (63%). They were less approving of current physician salaries 54/131 (41%) and prepaid health plans (35%). The majority of the written comments conveyed a concern about the disruption of the doctor-patient relationship due to current socioeconomic and political pressures on medicine.

Discussion. Descriptive research on the attitudes and historical practices of these elderly physicians can help us identify those aspects of medicine which rewarded and satisfied them. Our sample group was not a random sample of elderly Wisconsin physicians, and we cannot conclude that their experience is similar to the experience of elderly physicians in general, or even other senior Wisconsin physicians. Indeed, our study group's willingness to complete the survey, the contact we have had with them personally, and the nature of their responses make us suspect that they are not average elderly physi-

continued on page 16

Table 1—*Demographics and geographic stability of respondents*

	Characteristics	*Number of physicians (%)*
Age, year	61-65	39 (30%)
	66-72	41 (31%)
	>73	51 (39%)
Sex	Male	129 (98%)
	Female	2 (2%)
Began practice in hometown	Depression era	17/41 (41%)
	World War II era	4/30 (13%)
	Post World War II era	23/60 (38%)
Still reside where practiced	Depression era	36/41 (88%)
	World War II era	24/30 (80%)
	Post World War II era	53/60 (88%)

Table 2—*Reported income in dollars of responding elderly Wisconsin physicians v overall population*

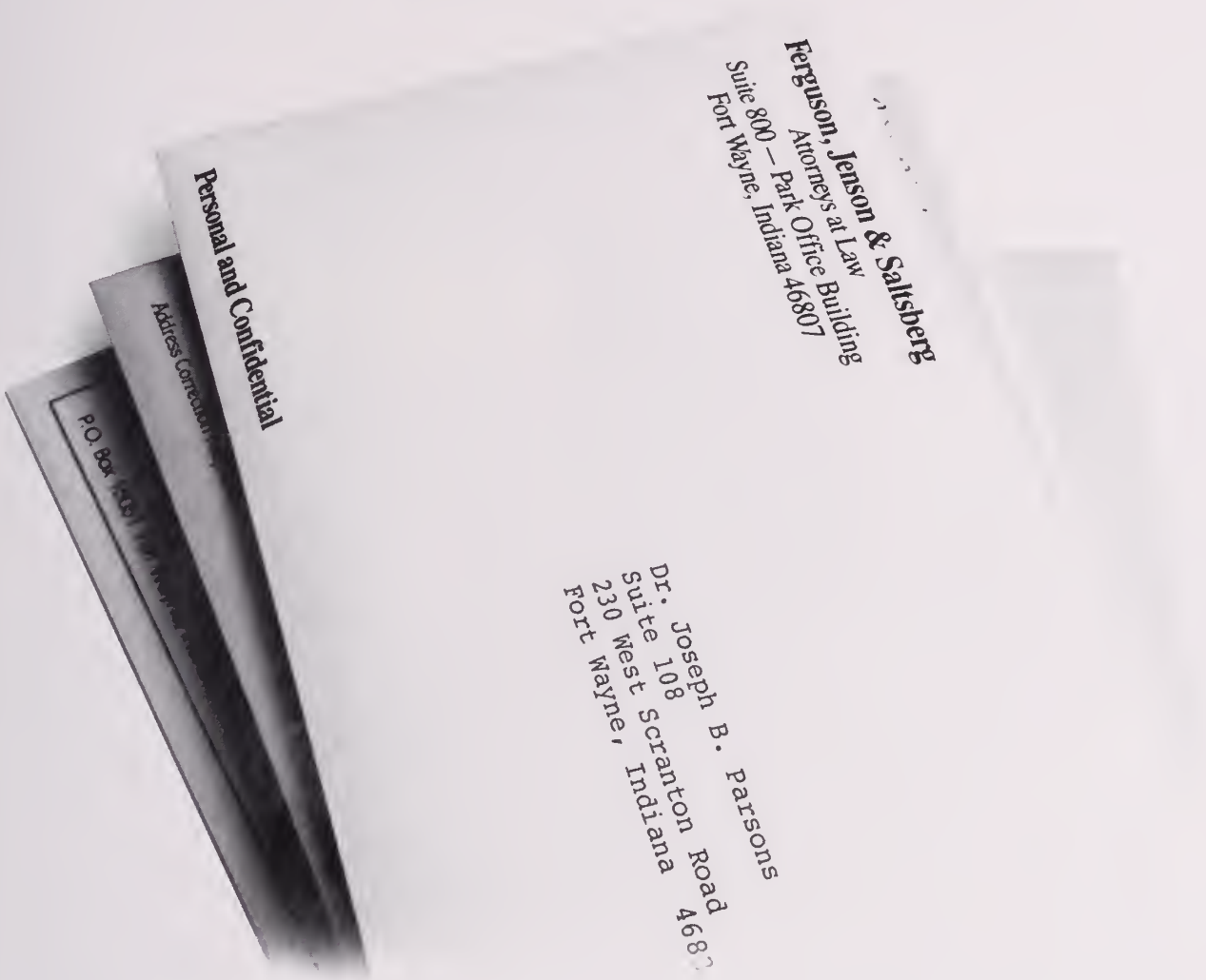
Reported income	*Percentage distribution of overall population in income bracket*	*Percentage distribution of physicians in income bracket*
Depression Era: (1926-1935)		
<5,000	90%	12 (32%)
5,000-7,499	2%	12 (32%)
7,500-9,999	2%	4 (11%)
10,000-14,999	2%	4 (11%)
>15,000	1%	6 (16%)
World War II Era: (1936-1945)		
<5,000	79%	4 (14%)
5,000-7,499	13%	6 (21%)
7,500-9,999	4%	2 (7%)
10,000-14,999	3%	5 (18%)
>15,000	1%	11 (40%)
Post World War II Era: (1946-1955)		
<5,000	49%	5 (10%)
5,000-7,499	26%	2 (4%)
7,500-9,999	12%	8 (16%)
10,000-14,999	7%	13 (26%)
>15,000	6%	22 (44%)

FROM: Historical Statistics of the United States, Colonial Times to 1970, US Department of Census, Bicentennial Edition, Part II, Washington, DC, 1975.

Table 3—*Fond recollections of older physicians (quotes)*

- When I first used sulfonamides and steroids.
- My first experience with penicillin—saving a man with pneumococcal meningitis.
- Caring for the severely and terminally ill.
- Patients who did well when unfavorable outcome was expected.
- Diagnosing unusual diseases.
- Removing a large carotid body tumor.
- Attitude of families after caring for them for many years.
- When a kindergarten class came to the hospital and they all said "that's my doctor."
- When my cleft palate patients became physicians, attorneys, architects, and good citizens.
- Letters I received from patients after my own surgery.
- Meeting with father and mother after delivering a child.
- Treating those who couldn't afford to pay—two days a week.
- Delivering triplets.
- The true love and kindness given me by most of my patients over the past 50 years.

Crisis in black and white.



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continued from page 14

cians, but rather a vigorous, happy, and fulfilled subset.

Therefore, our conclusions in this study must be limited to a description of the elements our respondents reported about their practices which may explain the favorable attitudes toward medicine that many of them share. The following are some of the things these physicians had in common:

1. good relationships with patients,
2. long duration of practices,
3. geographic stability,
4. community service and recognition,
5. adequate or excellent income,
6. voluntary, non-adversarial charity care,
7. approval of scientific aspects of medicine, and
8. disapproval of government intervention.

Each of these components requires further analysis before its relative contribution to physician satisfaction can be understood. Since career satisfaction was highest among physicians who began practice in the earlier eras, when stable general practice was more common, factors one through four above may have had a significant influence on physician satisfaction. These factors—the doctor-patient relationship, practice stability, and community service—are those aspects most threatened by recent changes in medicine.[2-9]

Why study the recollections of elderly Wisconsin physicians? Because, in uncertain times, the lessons of the past take on increased importance; we must learn about medicine in the "good old days" if we are to carry some good with us into the future.

Editorial comment: Doctor Schiedermayer et al's paper is about the doctor-patient relationship and the joy and satisfaction of being able to help people, as the list of fond recollections attests. I noticed there is no mention of the business aspect in the practice of medicine. These physicians practiced at a time when medicine was *the* honored profession and received and deserved respect and admiration.

Times have changed. Some physicians are no longer considered poor businessmen but entrepreneurs. These physicians are highly skilled in marketing, capital acquisition, merger, cost control, management, and so forth. What will be their fond recollections of this era?

—Enhancing revenue in spite of DRGs?
—Beating Medicare assignment?
—Containing malpractice losses?
—Reducing overhead?
—Establishing satellite programs?
—Establishing regional HMOs by merger?
—Containing costs?
—Finding a good tax shelter?

Change is inevitable, but from one perspective it seems changes in medicine over the last four decades have slowly but continually eroded the doctor-patient relationship. In some instances the business of medicine supercedes the needs of the patients.

If our's is to be regarded as a profession that takes care of patients, rather than as a collection of tradesmen selling to customers, the doctor-patient relationship must be enhanced by all practitioners.—RDS

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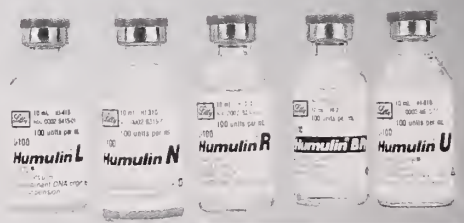

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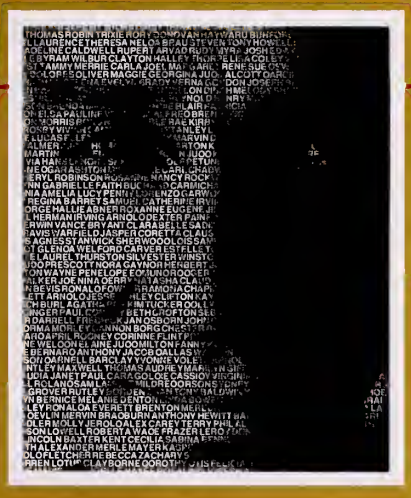

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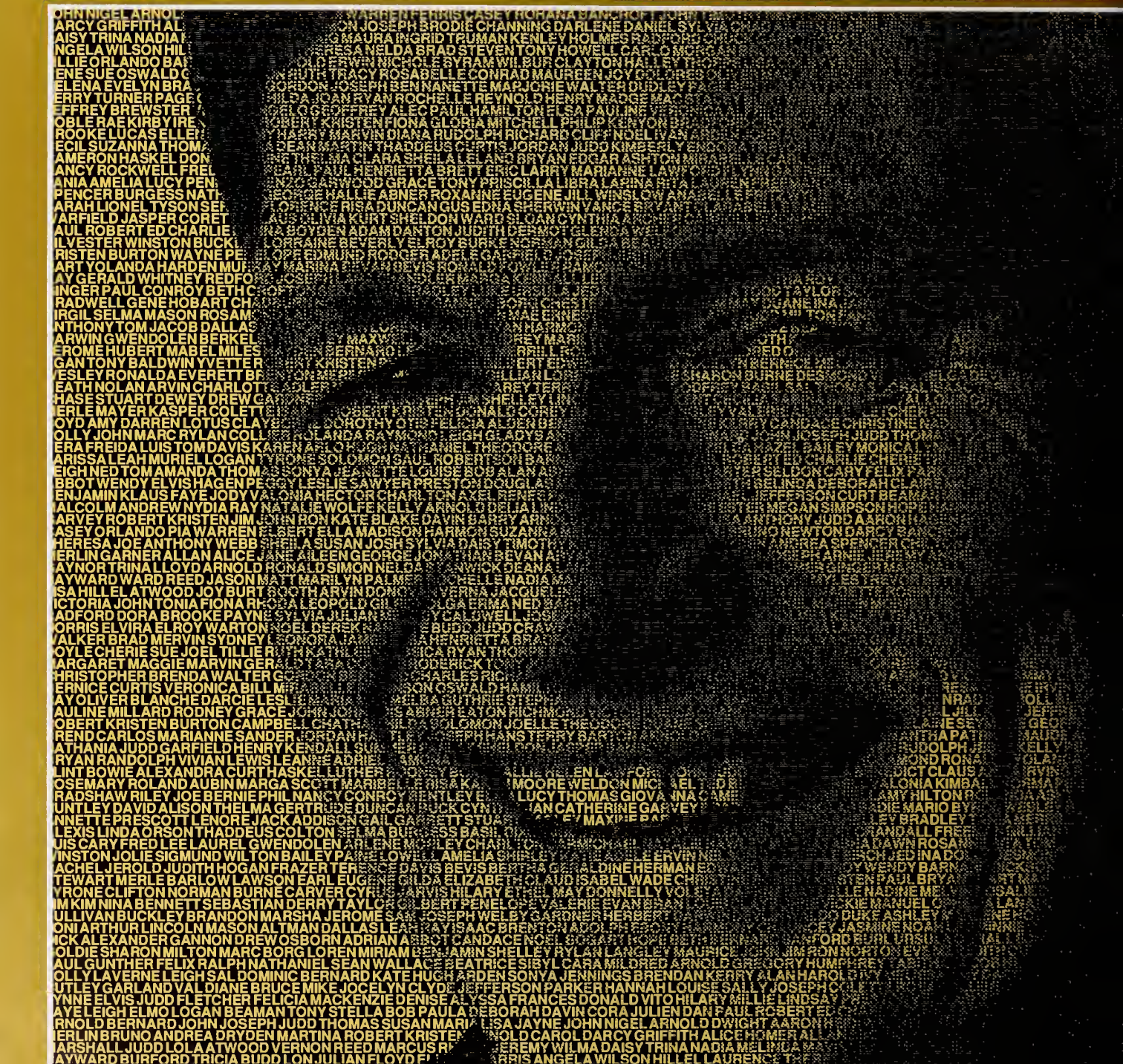

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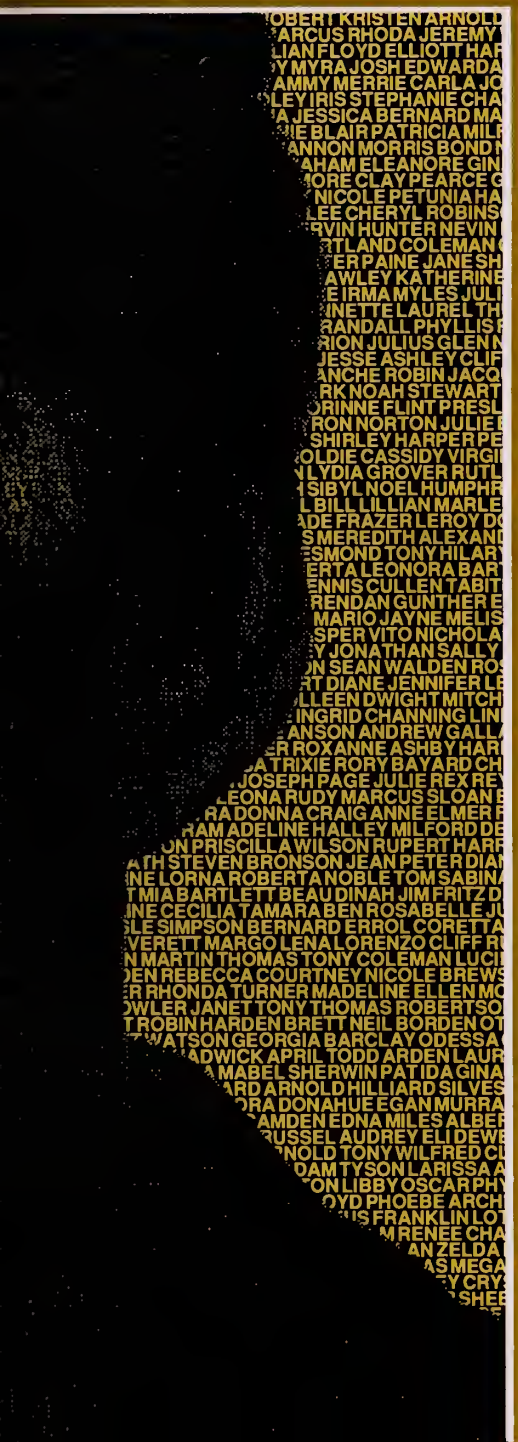

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BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure, and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3, and decreasing T_3.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL (propranolol HCl) is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, phenobarbitone, and *rifampin* accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and *lidocaine* have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Autoimmune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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Cryosurgical correction of Wolff-Parkinson-White syndrome using the closed heart technique

Tanvir Bajwa, MD; Robert Flemma, MD; Mohammad Jazayeri, MD; Stephen Denker, MD; Patrick Tchou, MD; Paul Werner, MD; and *Masood Akhtar, MD,* Milwaukee, Wisconsin

ABSTRACT. *The traditional surgical method for ablation of accessory pathways (APs) in Wolff-Parkinson-White (WPW) syndrome requires an endocardial approach and, therefore, necessitates cardiopulmonary bypass as well as hypothermic cardiac arrest. In this paper, we describe our experience with a newer technique first popularized by Guiraudon combining epicardial dissection of the atrioventricular (AV) sulcus followed by cryoablation. This technique interrupts AP conduction from an epicardial approach while maintaining a normothermic beating heart throughout the procedure.*

Twelve patients with WPW syndrome underwent this closed heart surgical technique at Mount Sinai Medical Center for ablation of APs associated with disabling tachyarrhythmias. There were 15 accessory pathways in 12 patients, 11 located in the left free wall and four in the postero-septal area as determined by preoperative and intraoperative mapping. Intraoperative evaluation revealed no evidence of functioning APs in these patients. All patients survived without significant morbidity, were cured of their ventricular preexcitation, and have not experienced recurrence of tachyarrhythmias during a three-to 20-month follow up.

Key Words: Wolff-Parkinson-White (WPW); Accessory pathways (APs); Orthodromic tachycardia (OT); Atrioventricular (AV).

From the Natalie and Norman Soref and Family Electrophysiologic Laboratory, University of Wisconsin-Mount Sinai Medical Center, Milwaukee. Publication support provided. Reprint requests to Masood Akhtar, MD, Electrophysiology Laboratory, Mount Sinai Medical Center, 950 N 12th St, Milwaukee, WI 53233. Copyright 1988 by the State Medical Society of Wisconsin.

The Wolff-Parkinson-White (WPW) syndrome results from an anomalous bypass tract (Kent bundle) consisting of myocardial fibers stretching across the atrioventricular (AV) sulcus. These fibers are capable of conducting antegradely, retrogradely, or in both directions bypassing the normal conduction system (atrioventricular node and His system).[1] Arrhythmias encountered in the WPW syndrome include reentrant supraventricular tachycardias and atrial flutter or fibrillation with fast conduction over the accessory pathways (APs). The most common type of reentrant tachycardia in patients with WPW syndrome is orthodromic tachycardia (OT) using normal pathway antegradely and APs retrogradely. During atrial flutter or fibrillation, an AP capable of sustaining fast conduction may produce rapid ventricular response, which could degenerate into ventricular fibrillation.[2] The first successful division of the AP was performed in 1969 by Sealy.[3] Since then, the surgical technique has improved substantially and, as a result, criteria for patient selection have become less rigid.[4-11]

At the present time, surgery seems to be the preferred option in patients with life threatening atrial flutter-fibrillation or disabling reentrant tachyarrhythmias refractory to drugs. Aside from these groups of patients, surgical therapy provides a feasible alternative with low risk and a high success rate, particularly in young individuals who are otherwise committed to life-long antiarrhythmic drug therapy. In this communication we present our experience with a new surgical approach that has compiled a remarkable safety and efficacy record.

Methods. Our patient population consists of 12 cases referred to Mount Sinai Medical Center, Milwaukee, for electrophysiologic evaluation and surgery for WPW syndrome between October 1985 and April 1987. There were nine men and three women, ages 17 to 41 years ($\bar{x} = 26.8 \pm 6.9$ years) (Table). Four patients were refractory to medical management, and eight patients chose surgical treatment over life-long drug therapy. No patient had any associated structural heart disease. All patients underwent extensive preoperative electrophysiologic evaluation using the techniques previously described from this laboratory[12-14] to:

- confirm the presence and number of APs;
- assess the role of APs in the genesis of clinical tachycardias;
- localize site or sites of the APs;
- detect other arrhythmias not involving APs; and
- assess the efficacy of antiarrhythmic drugs.

Ten patients had delta waves on EKG (manifest pre-excitation), while two patients had concealed accessory pathways capable of conducting only in the retrograde direction. All patients had inducible orthodromic tachycardia (146 to 240 beats per minute; $\bar{x} = 189 \pm 31$; see Table). Four patients had potentially life threatening atrial fibrillation with a rapid ven-

tricular response. The ventricular rate during atrial fibrillation ranged from 210 to 260 beats per minute ($\bar{x} = 230 \pm 22$). One patient had experienced two episodes of ventricular fibrillation following inappropriate therapy (ie, intravenous digoxin on one occasion and verapamil on another) in the emergency room for atrial fibrillation and AV conduction over the APs.

Surgical Technique. The heart was exposed through a median sternotomy. Intraoperative epicardial mapping during sinus rhythm, paced atrial rhythm, paced ventricular rhythm, and reentrant tachycardia was performed to verify the site or sites of APs prior to cardiopulmonary bypass (Fig 1-A). After completion of epicardial mapping, ablation of APs was carried out on the beating heart under normothermic cardiopulmonary bypass.[4]

The closed heart technique combined mobilization of the AV fat pad with local dissection and cryosurgery (Fig 1-B, 1-C). The epicardium of the AV fat pad was incised along its atrial limits. An incision, 4 to 5 cm long, was centered on the atrial insertion of the Kent bundle. The fat pad was then dissected free from the atrial wall. Atrial veins were ligated and divided, and care was taken to avoid injury to the coronary sinus and circumflex artery. The left atrial branch of the circumflex artery was tied and divided. At that time, the AV fat pad containing the circumflex artery and coronary sinus could be mobilized up onto the left ventricle exposing the AV junction. Following dissection, repeat mapping was performed to assess the presence of any residual conduction along the previously mapped pathways or additional pathways not previously documented or suspected.

Cryosurgery was used to produce freezing injury to the AV junction and adjacent ventricular and atrial walls at the site of Kent bundle insertion in order to ensure ablation of the latter (Fig 1-C). Multiple applications of the cryoprobe, 1.5 cm in diameter, were used (−70°C for 2 minutes). The fat pad and its vessels were retracted away from the cryoprobe under direct vision to avoid injury.[14] At that point, all possible sites of Kent bundle insertion over the atrium had been divided or cryoablated. Normothermic cardiopulmonary bypass with beating heart was used in all the patients, and average pump time was 82 minutes (range, 45 to 50 minutes). The use of cardiopulmonary bypass was a precautionary measure to safeguard against hypotension during dissection, especially of the postero-septal area, since the heart is usually lifted up during dissection and cryoablation of this area. Before closing the chest, pairs of temporary epicardial pacing electrodes were implanted over each cardiac chamber for postoperative stimulation studies.

Patient characteristics

Case	*Age/Sex*	*Duration Of Sx's In Years*	*Location of Accessory Pathway*	*Clinical Arrhythmia Rate/Minute*	*Post Operative Follow-Up (Months)*
1	22/F	8	Left Freewall	OT* (240)	20
2	35/M	30	Left Freewall	OT (146)	15
3	26/M	16	Left Freewall Concealed	OT (230)	11
4	30/M	16	Left Freewall Postero septal	OT (222)	11
5	21/F	7	Left Freewall	OT (146)	11
6	17/M	1	Postero septal	OT (181)	11
7	41/M	28	Left Freewall	OT (178)	7
8	24/M	10	Left Freewall Postero septal	OT (180) A Fib† (220)	7
9	26/M	8	Left Freewall	OT (150) A Fib (260)	7
10	33/M	25	Left Freewall	OT (215) A Fib (230)	3
11	27/M	1	Left Freewall	OT (188) A Fib (210)	3
12	20/F	15	Postero septal Left Freewall	OT (193)	3

*OT = Orthodromic Tachycardia
†A Fib = Atrial Fibrillation

Results. There were 15 accessory pathways in 12 patients, 11 located in the left free wall and four in the postero-septal area (Table). An excellent correlation between preoperative and intraoperative location of APs was found in all patients. Three patients had multiple APs as suspected during preoperative evaluation (Table). Pre-excitation disappeared in all patients during dissection of the atrioventricular fat pad. Successful ablation of the APs was verified by intraoperative evaluation of antegrade and retrograde conduction during atrial as well as ventricular pacing respectively, both following dissection and then again after cryoablation. During incremental atrial pacing no evidence of pre-excitation could be demonstrated. With ventricular pacing intact retrograde conduction was seen in nine of 12 cases. However, the behavior of retrograde conduction was typical of the atrioventricular node since a progressive prolongation occurred at faster pacing rates and intravenous verapamil produced a depressant effect. Following cryoablation, orthodromic tachycardia could not be initiated in any of the patients.

All patients underwent multiple stimulation studies postoperatively prior to their discharge using temporary pacing electrodes. There was no evidence of conduction through any of the APs that were functional preoperatively. Figs 2-A, 2-B, and 2-C, taken from patient seven, show a typical example of preoperative ventricular pre-excitation (Fig 2-A), or-

thodromic tachycardia (Fig 2-B), and abolition of pre-excitation (Fig 2-C) following surgery.

Complications. All patients tolerated the surgery well without major complications. One patient had excessive intraoperative bleeding due to right atrial laceration, and another patient had ventricular fibrillation in the recovery room due to metabolic derangements requiring DC cardioversion. No long-term sequelae developed from any of these complications. There were no deaths, no reoperations were needed, and none of the patients developed postcardiotomy syndrome. Hospital stay was five to nine days ($\bar{x} = 6.4 \pm 1.2$ days).

Follow-up. All patients underwent electrophysiologic evaluation two months postoperatively. There was no evidence of functional APs in any of the patients on follow-up study. All the patients remained free of arrhythmias without medication after a follow-up period of three to 20 months ($\bar{x} = 9 \pm 5$ months).

Discussion. The efficacy of the epicardial, closed heart technique in ablation of APs is similar to that of the endocardial open heart technique (Fig 1-A, 1-B, 1-C, 1D).[5,8,9] The advantages of the epicardial technique are as follows:

- Existing data suggest that most accessory pathways cross the AV sulcus subepicardially, so it is only natural to approach these pathways through the epicardium.
- The closed heart technique is performed on the normothermic beating heart and, therefore, does not require hypothermic cardiopulmonary bypass, cardioplegia or aortic cross clamping.

Normothermic cardiopulmonary bypass, however, may be employed as a safeguard against hemodynamic decompensation as was done in this series during intraoperative mapping, especially when the heart was lifted up and during tachycardia.[4,5,6]

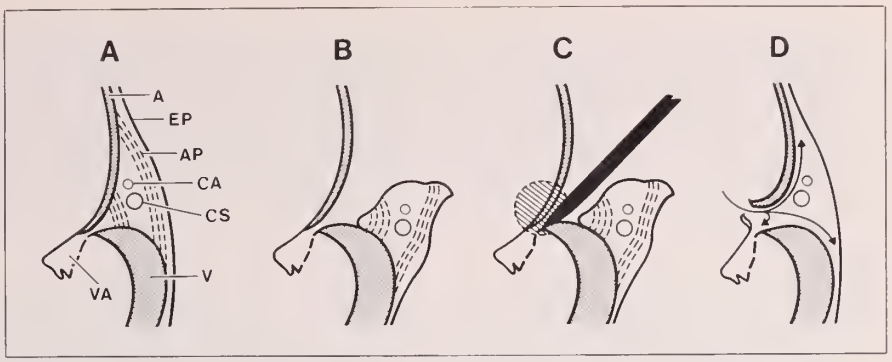

Fig 1-A,B,C,D.—*The anatomic location of left sided accessory pathways (APs) and surgical technique. A) shows a cross-section of the left coronary sulcus. Dotted lines stand for possible location of APs. B) and C) show the closed heart technique, which combines mobilization of atrioventricular (AV) fat pad and cryoablation of AV junction; D) presents the open heart technique. Arrows indicate site of division and dissection. (A = atrium; V = ventricle; Ep = epicardium; AP = accessory pathways; VA = valve annulus; CS = coronary sinus)*

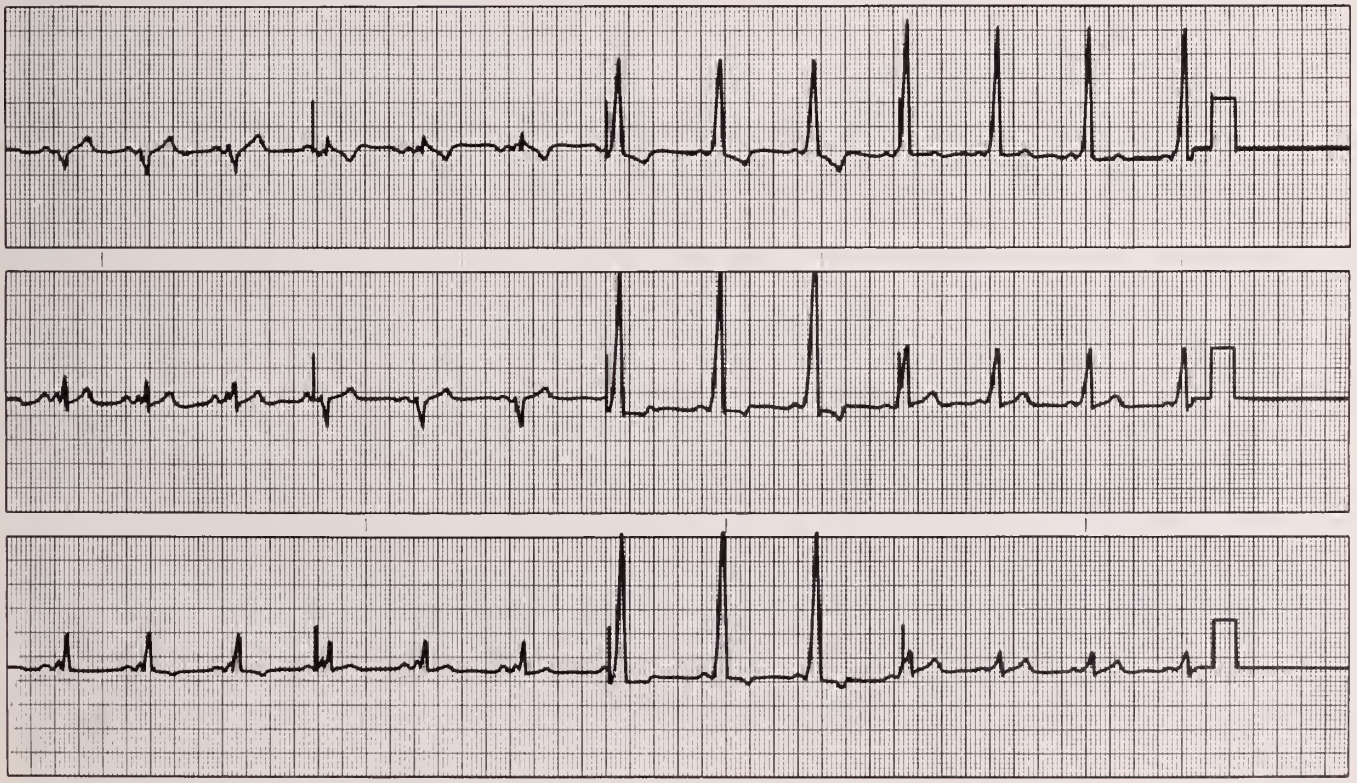

Fig 2-A.—*Preoperative 12-lead electrocardiogram showing short PR interval, positive delta waves in inferior and precordial leads, negative delta waves in I, AVL, suggestive of left free wall AP.*

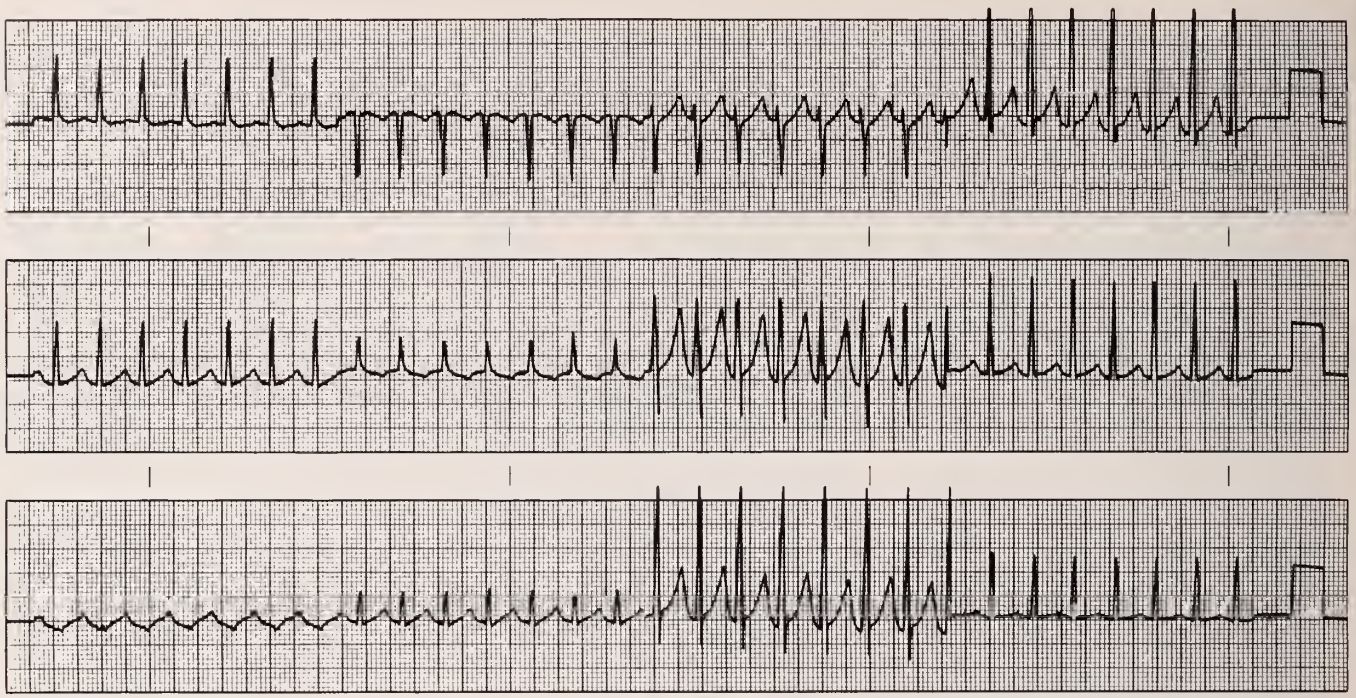

Fig 2-B.—*Preoperative electrocardiogram. A narrow QRS complex reentrant supraventricular tachycardia (orthodromic tachycardia) using normal pathway for anterograde and AP for retrograde conduction.*

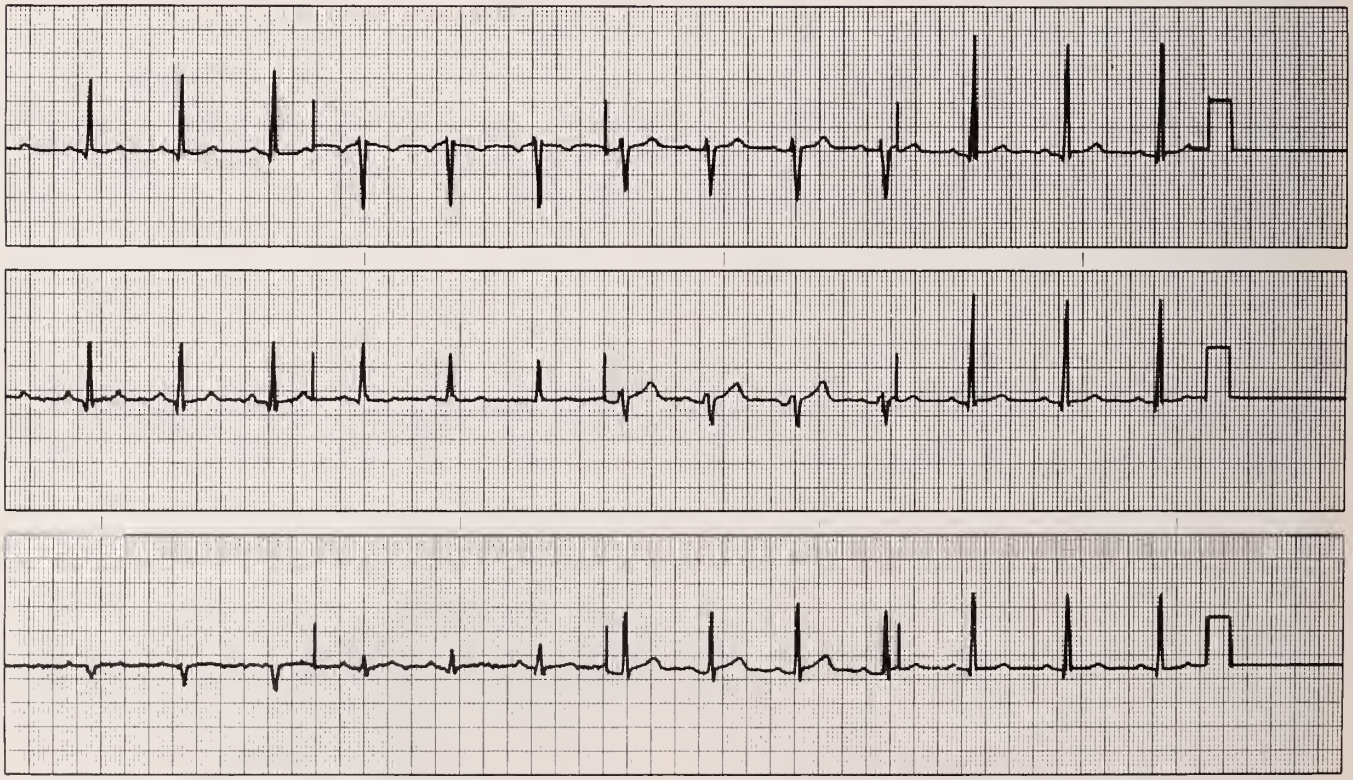

Fig 2-C.—*Postoperative electrocardiogram. Note the absence of delta wave and normal PR interval.*

- No mortality has been reported by any series in the literature using the closed heart technique, whereas overall mortality reported with the open heart technique is 5%.[8,15] Potentially lethal complications, such as severe myocardial damage due to cold cardioplegic arrest, can therefore be avoided by using the epicardial approach.[16,17] The use of cryoablation produces little added morbidity. Lesions produced by cryosurgery usually turn into dense well-delineated nonarrhythmogenic scar.[3,18,19]

The incidence of permanent complete heart block with open heart technique is 0.8%. However, by continuously monitoring AV conduction throughout the procedure during the use of epicardial technique, none of the patients in our series developed permanent complete heart block.[8] There also appears to be a high incidence of postoperative atrial fibrillation with the use of the open heart technique thought to be secondary to infusion of cardioplegic solution.[20] In our series none of our patients suffered atrial fibrillation in the postoperative period.

We conclude that the closed heart epicardial approach for ablation of APs in WPW syndrome demonstrates excellent efficacy with low morbidity and mortality. On the basis of results obtained in this series of patients and other series in the literature, we now consider this type of surgery to be a preferred alternative to a lifetime of medical therapy in young and otherwise healthy patients with WPW syndrome.

Addendum. Since compilation of these data, two additional patients, ages 24 and 37 years, have undergone successful cryoablation for WPW syndrome. One patient had a single AP in the left free wall, and the other had two APs in the left free wall and posterior septal location respectively. Both had an uncomplicated hospital course.

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ABSTRACT

Thyroid gland size in pregnancy: An ultrasound and clinical study

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We estimated the size of the thyroid gland by palpation and measured thyroid gland volume with ultrasound in the immediate postpartum period and six months after delivery in 16 women. The 13% reduction in the mean thyroid gland volume detected six months after delivery implied that the thyroid gland enlarges slightly during pregnancy. Physical examination, however, did not detect any goiters during the immediate postpartum period and did not identify a change in thyroid gland size 6 months after delivery. The thyroid gland enlargement that occurs during pregnancy is not large enough to be detected by physical examination. We urge physicians to discard the commonly held notion that goiter frequently develops during pregnancy.■

Transcatheter treatment of heart disease in infancy and childhood

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ABSTRACT. *Transcatheter therapy is used more frequently than in the past to treat many cardiovascular disorders in infants and children both because the material and technology are available for developing innovative catheters and because pediatric patients with heart disease are being managed more aggressively. This paper reviews the various techniques available to clinicians, with an emphasis on balloon dilatation of stenotic lesions, and discusses the advantages and disadvantages of each procedure. The author recommends refinement of technique or device used and additional clinical trials where appropriate.*

Key words: Transcatheter therapy; Balloon angioplasty; Atrial septal defect; Intracardiac foreign bodies; Balloon valvuloplasty; Blade septostomy; Patent ductus arteriosus; Laser

THE CONVENTIONAL treatment of choice for structural abnormalities of the heart and blood vessels, whether congenital or acquired, is surgical correction. But during the last decade there has been an enormous increase in the use of transcatheter techniques to improve or correct structural defects in the cardiovascular system. The purpose of this review is to discuss these newer modalities of treatment.

Transcatheter treatment by balloon dilatation of stenotic lesions was first described by Rubio and Limon-Lason[1] in 1954 and later by Dotter and Judkins[2] in 1964. But until recently only transcatheter balloon atrial septostomy for palliation of transposition of the great arteries described by Rashkind[3] in 1966 was widely used. Over the last decade, however, balloon dilatation techniques in all vascular and valvular stenoses—both in adults and children—have become more common partly due to the work of Gruntzig and associates.[4]

Transcatheter treatment can be classified into seven subheadings:

- Balloon dilatation of stenotic lesions
- Transcatheter balloon and blade atrial septostomy
- Catheter closure of patent ductus arteriosus and atrial septal defects
- Selective embolization of abnormal blood vessels
- Transcatheter removal of foreign bodies
- Transcatheter His bundle ablation
- Transcatheter laser applications

In this review, balloon dilatation of stenotic lesions will be discussed in detail and the others mentioned briefly.

Balloon dilatation of stenotic lesions. Balloon dilatation of valvular lesions by a pullback or dynamic technique was described by Rubio and Limon-Lason[1] in 1954 and by Semb[5] in 1979, but the technique of static dilatation as it is now used was first described by Kan and associates[6] in 1982. This technique has been used in infants, children, and adults to relieve congenital, acquired, and postoperative stenotic lesions of the pulmonary valve, peripheral or main pulmonary artery, pulmonary vein, aortic valve, mitral valve, descending aorta (coarctation of the aorta), interatrial baffle after Mustard's operation for transposition of the great arteries, and superior vena cava.

The technique consists of introducing a guidewire across the stenotic lesion (usually through an end-hole catheter already in place), advancing a balloon dilatation catheter over the guidewire so that the stenotic lesion is located in the middle of the balloon, and rapidly inflating the balloon with diluted contrast material. The recommended size of the balloon varies with type of stenotic lesion to be dilated, eg, 1.2 to 1.4 times the size of the pulmonary valve annulus in pulmonary valve stenosis,[7] no larger than aortic valve for aortic stenosis,[8] 2.0 to 2.5 times the size of coarcted aortic segment but no larger than the descending aorta at the level of diaphragm,[9,10] and three to four times the size of the pulmonary arterial or venous stenotic lesions.[11] Pressure used during inflation of the balloon is between 4 and 8 atm depending on the lesions to be dilated. Although the initial recommendations for the duration of balloon inflation are between 10 and 60 seconds, short inflation duration (5 seconds) appears adequate and does not cause significant drop in systemic pressure or perfusion.

The relief of obstruction is seen in the sudden disappearance of "waisting" of the balloon, fall in transstenotic pressure gradient, and increase in the size of the stenotic area by angiography. In general, balloon dilatation effectively relieves valvular stenotic lesions; it shows variable results with central arterial (pulmonary artery and aorta) stenotic lesions; and it seems least effective with venous (pulmonary or systemic venous) stenotic lesions.

Direct visual observation of pulmonic and aortic valves in a few patients immediately following balloon dilatation show tearing of the valve raphe and tearing or avulsion of the valve leaflet.[12] The mechanism for relief of arterial stenotic lesions appears to be tearing of the intima and media of vessel wall.[10,11]

The risks in surgical relief of most of the stenotic lesions are low, but open heart operations still have many disadvantages, including prolonged hospitalization, scarring from the operation, and greater cost. For these reasons alone, catheter techniques may be preferred.

Successful immediate results in pulmonary valve stenosis with indication that relief persists suggest that percutaneous balloon dilatation is the treatment of choice for moderate to severe pulmonary valve stenosis.[9] Although the long-term results of balloon dilatation for coarctation of the aorta are not yet estab-

From the Department of Pediatrics, University of Wisconsin-Madison. Supported in part by a grant from the Oscar Rennebohm Foundation, Inc. Reprint requests to: P Syamasundar Rao, MD, Division of Pediatric Cardiology, UW Hospital and Clinics, 600 Highland Ave, Madison, WI 53792 (phone: 608/263-8535). Copyright 1988 by the State Medical Society of Wisconsin.

lished, the short-term results are encouraging. In light of the high risk of surgical resection of coarctation of the aorta in neonates and small infants (especially when other intracardiac anomalies are present), a high incidence of recurrence (10% to 30%) and difficulties encountered during reoperation, balloon dilatation of coarctation of the aorta offers a safer and effective alternative.[13] With balloon dilatation, surgery may be avoided or at least postponed until the infant is larger and the risk of death or recoarctation is lower. Recurrence in stenosis or the development of aneurysm at the site of dilatation can be treated by surgical resection when the acute illness has passed. Published reports indicate that balloon dilatation for restenosed coarctation is consistently effective without any complications.[14] However, balloon dilatation should not be performed routinely in older children with native coarctation until the risk of aneurysm has been assessed in long-term studies.[9 15] The role of balloon dilatation in aortic stenosis is not clearly established, but the results of balloon dilatation of mitral stenosis are encouraging.[16 17]

A relatively new application of the technique[18] is dilatation of pulmonic valve stenosis in patients with complex cyanotic heart defect. We have had good success with the technique in infants who are not candidates for total correction either because of their size or the complexity of their cardiac problem. This has eliminated the need for immediate palliative shunt surgery by augmenting pulmonary blood flow by balloon dilatation of pulmonic valve and will, we hope, make the patients better candidates for surgery at a later date.

Balloon and blade atrial septostomy. Rashkind's balloon atrial septostomy has been used extensively in the initial palliation of transposition of the great arteries in neonates until surgical correction by venous switch procedures can be performed safely. Enlargement of the atrial defect by this technique, which allows easy egress of blood from one atrium to the other, has also been useful in the palliation of mitral atresia, tricuspid atresia, pulmonary atresia with intact ventricular septum, and total anomalous pulmonary venous connection. In older infants and children, the lower margin of the patent foramen ovale is thick and muscular and cannot be torn by the balloon. To circumvent this problem, Park[19] developed a catheter with a built-in retractable blade to cut the lower margin of patent foramen ovale, which can then be enlarged by atrial septostomy. We[20] and others[21] have used this technique successfully in the palliation of complex congenital heart disease in older infants and children.

Closure of patent ductus arteriosus and atrial septal defect. Several types of devices (plugs and umbrellas) have been developed by Portsman,[22] King,[23] and Rashkind[24] for transcatheter closure of patent ductus arteriosus and atrial septal defect. The technique is effective, but because of the bulky size of the catheter delivery system and the extremely low mortality and morbidity rates of surgical closure of these defects, it has not gained wide popularity. Further refinement and miniaturization of these devices and additional clinical trials are necessary prior to general use.

Selective embolization. There has been limited but successful experience in selective embolization of abnormal blood vessels in pediatric patients.[25 26 27] The materials used may be absorbable biodegradable materials such as Gelfoam (sheets and powder) or nonabsorbable particulate materials such as silicone spheres, Ivalon, isobutyl-2-cyanoacrylate (ICBA), silicone fluid mixture, tantalum powder, gianturco coils, and silicone balloons.[28 29 30] Pediatric applications include occlusion of Blalock-Taussig shunts, blocking of collateral vessels to the lung in tetralogy of Fallot and pulmonary atresia, embolization of pulmonary arteriovenous malformations, therapeutic obliteration of arterial supply to the sequestered portion of lung in infants with scimitar syndrome and congestive heart failure, patent Glenn anastomosis, and other types of arteriovenous malformations.

Removal of foreign bodies. Removal of foreign bodies, including inadvertently embolized polyethylene catheters, fragments of guidewires and catheters dislodged during cardiac catheterization, pacing catheters, and detached cerebral ventriculo-atrial shunts is possible with several catheter techniques.[31 32] These complications can be prevented, however, by meticulous attention to inserting and securing the intravenous catheters, use of radiopaque catheters, which may be easily located in the event of inadvertent embolization, and prompt removal once the foreign body is embolized.

His bundle ablation. The use of transcatheter His bundle ablation for controlling junctional automatic ectopic tachycardias unresponsive to conventional measures[33] and similar techniques to ablate the Kent bundle are feasible in pediatric patients, but more clinical experience and further refinement of the technique are required.

Laser techniques. Transcatheter laser techniques have been used to produce atrial septal defects and to relieve stenotic lesions in postmortem and animal studies.[34,35] This technique requires further development in animal models followed by clinical trials.

Summary. Many transcatheter techniques and procedures are available to the clinician to correct or palliate cardiac problems in infants and children. Miniaturization of bulky catheter systems and refinement of the techniques are necessary to further enhance the transcatheter approach as an option to surgical intervention.

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CLINICAL CANCER: Number 23 of a series

Cancer pain control: use of nonparenteral analgesics

Roger W Kwong, MD
La Crosse, Wisconsin

The Cancer Control Program of the World Health Organization has made relieving cancer pain a priority, and the Wisconsin Pain Initiative for Improving Cancer Pain Management has been named as a model plan. Fulfillment of this priority, however, is hindered by misconceptions or lack of information among patients, their families, and medical professionals. With that in mind, this article will provide information about the most generally used method of cancer pain control: oral narcotics.

Planning pain control. Effective pain management requires the skills of medical evaluation. Because some patients may feel that pain is to be expected and endured, physicians need to ask about pain. A patient's history should document the character of the pain and include a quantitative assessment, and a physical examination is needed to determine which anatomic structures are involved. An assessment is then made as to the cause of the pain so that the appropriate therapy can be determined. For example, spiritual pain does not respond well to narcotics. Treatment of the cause of pain is the most effective therapy, but until it is accomplished—or if it is not possible—the pain should be controlled symptomatically. Oral analgesics are commonly used for symptomatic pain control.

Step-ladder progression. Oral analgesics should be used in what has been referred to as a ladder progression. The ladder begins with largely over-the-counter, non-narcotic analgesics, including acetaminophen and the nonsteroidal anti-inflammatory drugs (NSAID), for mild pain. The

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Physicians are encouraged to contact the authors if they wish to discuss these topics further or obtain additional information. Comments or suggestions for topics would be welcome.

second rung uses the schedule III narcotics for moderate pain, and the top rung uses the schedule II narcotics for severe pain.

For example, the ladder progression may start on the first rung with two tablets of acetaminophen every four hours to control mild pain (assuming that aspirin is to be avoided because of its antiplatelet activity). If the pain is not controlled, an NSAID such as ibuprofen can be added up to 2,400 mg per day, in divided doses.

Moderate pain can be controlled with drugs on the second rung, such as acetaminophen (325 mg) with codeine (30 mg), two tablets every four hours. If nausea or constipation is a problem, a low-dose schedule II drug could be used.

Controlling severe pain requires stepping up to the top rung—a schedule II drug. Dilaudid (4 to 8 mg, every four hours) may be one of the easiest. It is generally available, has a moderate duration of action without a long excretion half-life, and is absorbed well orally.

Morphine is another good choice, although it may take longer to titrate because of its greater variability of absorption. Start with a short-acting form as needed, with a short interval (eg, two hours). Switch to an equal milligram amount of a long-acting form when a stable dose has been established. The total number of tablets is given in divided doses at 8- to 12-hour intervals. The large doses sometimes required for good pain control (up to 300+ mg, every four hours) may be frightening to all concerned if they are not familiar with the need for such doses.

Setting the dosage and schedule. Because cancer pain is constant, a regular schedule of analgesic drugs is preferable to an as-needed schedule. It is also desirable to have a time schedule that is convenient for both the patient and the care provider. This may require altering the drug, the amount per dose, and the interval between doses. If a long-acting form is used—and there may be brief exacerbations when a short-acting drug is needed—morphine may be preferable because of its multiple dose forms. One common variation is using a drug every four hours during the day, with a double dose at bedtime to last an eight-hour interval. Any drowsiness from the double dose would be unacceptable during the day, but may be desirable at night.

When starting a new drug, it is necessary to titrate to the proper dose by varying the amount or interval. Start with a dose calculated to give quick pain relief, then vary the dose for the desired interval. Calculations of equianalgesic doses are based on single starting doses. Drugs such as levorphanol and methadone have longer half-lives and are more difficult to use. Caution is needed after three or four doses to avoid toxicity, especially in the elderly and patients with hepatic impairment. Side effects should be the only reason that use of more than one narcotic at a time is necessary; an adequate dose level is more likely to be found if just one drug is used.

The effective dose may be more than one or two tablets of a given drug. The Wisconsin Board of Pharmacy has recognized this by interpreting the federal regulations limiting narcotics to 120 doses as meaning 120 dosages; ie, if a patient is taking two hydromorphone (4 mg) tablets every four hours, then 240 tablets could be prescribed and dispensed. The proper dose is that which provides pain relief.

Selecting the narcotic. There are many drugs, but the physician needs to become familiar with only a few to be effective. Which schedule III or schedule II drug is used depends upon the physician's preference, the patient's tolerance, and the drug's availability. There are tables of dose equivalents and suggested starting doses. Regardless of which narcotic is used, the dose needs to be titrated to provide pain relief with little or tolerable side effects. While narcotics have similar side effects, the degree of these effects may differ from patient to patient. If unacceptable side effects occur, switch to another agent, using the first agent and an equianalgesic dosage table to estimate the starting dose.

The choice of a narcotic may also depend upon the availability of a convenient dose size and form. The order of increasing potency inversely correlates with the general availability of these medications to the patient. While the narcotic components

Oral analgesics

Drug	*Dose*	*Relative strength*	*Cents per dose*
acetaminophen 325 mg	2 tabs	1	4–5
acetaminophen 500 mg	2 tabs	1.5	7–20
acetaminophen 650 mg	1 supp	1	33–46
ibuprofen OTC 200 mg	2 tabs		5–20
ibuprofen 400 mg	1 tab		10–12
acetaminophen 325 mg with codeine 30 mg	2 tabs	2	14–22
acetaminophen 325 mg with oxycodone 5 mg	2 tabs	5	25–28
hydromorphone 4 mg	1 tab	6	42–48
hydromorphone 4 mg supp*	1		154–180
levorphanol 2 mg tab*	2 tabs	4–6	64–74
methadone 10 mg tab*	2 tabs	4–6	13–25
morphine 15 mg tab	4 tabs	4–6	61–86
morphine 30 mg long acting tabs	2 tabs	4–6	134–244
morphine 20 mg supp*	3 at once	4–6	360–366
morphine 20 mg/5 ml soln*	15 ml	4–6	122
morphine 10 mg/5 ml soln*	30 ml	4–6	140–193

*Not carried in stock by all pharmacies. Generally available in one or two working days.

of fixed combinations can be effective, the higher number of dose forms needed for a high degree of potency can result in an excessive amount of acetaminophen. Morphine is more widely used orally now than 10 years ago because of the new dose forms. It is available as a solution which can be used in patients who have difficulty with pills or who need to have their analgesics administered through feeding tubes. Morphine tablets are available in regular short-acting (T1/2 = 2 to 3.5 hours) or long-acting (T1/2 = 4.8 hours) forms. The long-acting forms are more slowly absorbed and excreted. They are meant to be used for chronic pain. Rectal suppositories are also available.

For a physician who does not regularly prescribe narcotics, it is advisable to call the pharmacist and ask what is in stock, or when a particular drug would be available. This will ensure that the patient can begin the analgesic and promptly obtain relief.

Cost should also be considered in determining which drug to use. At large doses, a particular form may not be economical or convenient to use, and an alternative form or drug may be preferable. For very severe pain, morphine may be the choice because of the variety of dose forms and characteristics, which can be combined to provide freedom from the fear of cancer pain. The accompanying table lists common drugs, their dose equivalency, cost per dose, and availability based on a survey of a local clinic pharmacy and branches of three state-wide pharmacy chains.

Alternatives to oral medication. Advanced cancer is usually associated with anorexia and cachexia. The weight loss comes largely from loss of muscle mass. Intramuscular injections of analgesics may be painful and are to be avoided. Subcutaneous absorption may be slow and erratic. Rectal suppositories, when available, may be useful when the patient cannot swallow. Oral narcotic solutions given sublingually have not been studied well, but can be tried if the situation arises where intestinal administration is difficult. For the cancer patient, the most appropriate methods of chronic administration of narcotic analgesics are oral, intestinal tube, and intravenous.

Myths about cancer pain. Misinformation may prevent the cancer patient from having good pain control. The patient with incurable cancer need not be concerned about physical or psychological addiction, because the narcotics will be needed until death. Nor is there need to be concerned about the possible development of drug tolerance. The most common cause for escalating drug dosages is an increase in physical pain. Regularly scheduled dosages, in adequate amounts to give continuous pain control, will reduce concern about the next dose. Respiratory depression is most likely to occur with accumulating blood levels when dosages are being increased, especially when using a long-acting drug at short intervals.

When death is imminent, sedation, mild confusion, and even respiratory depression may be acceptable if the choice is between these side effects and severe pain. Adjuvants can also be useful in controlling side effects (eg, an antiemetic for induced nausea). Adjuvants can be used to reduce the narcotic dose required (eg, an NSAID with a narcotic). Adjuvants are not always needed. Pain-control cocktails of fixed combination are no longer recommended for general use. They have been made obsolete by the large number of drugs, dose sizes, and forms now available.

Summary. There are several excellent references that describe the types of cancer pain syndromes and the options for treatment.[1,2] Most clinical oncology texts contain similar discussions. There are educational and resource materials on cancer pain control for physicians, nurses, allied health professionals, patients and their families available on request from the Wisconsin Division of the American Cancer Society in Madison.[3-5] The manufacturers of analgesics have printed materials on cancer pain control, too.

Good pain control for the cancer patient is usually possible with appropriate drug selection, dosage, and regular scheduling. Good pain control can be provided to any cancer patient by his or her physician in consultation, when needed, with pain-control teams at the cancer treatment center. Cancer pain should not be neglected. It is treatable. When cancer pain is controlled, the quality of life for patients and their families is greatly improved.

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A CLINICIAN'S GUIDE TO AIDS AND HIV INFECTION IN WISCONSIN.
The Wisconsin Division of Health is offering this informational document to all physicians and healthcare personnel. (Some 12,000 copies have been mailed to all licensed physicians in Wisconsin, nurses, and other healthcare personnel.) Written by Edward Belongia, MD, with technical assistance by other members of the AIDS/HIV Program staff, the document contains information pertaining to patients who may encounter the acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection. The number of individuals with HIV infection is increasing nationwide, with an estimated 1-2 million people already infected. The document is available by writing to AIDS/HIV Program, Wisconsin Division of Health, 1 West Wilson St, PO Box 309, Madison, WI 53701; or phone 608/267-5287.■

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†Pooled mean serum potassium following oral administration of 30 mEq K-Tab compared to 24 mEq Slow-K in diuretic-treated hypertensives (n = 20) over 8 weeks.

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1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.
2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function, potassium-losing nephropathy, and certain diarrheal states.
3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS
Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS
Hyperkalemia (See OVEROOSAGE).
In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly caretul monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics
Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions
Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis
Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS
General:
The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients
Physicians should consider reminding the patient of the following:
To take each dose without crushing, chewing, or sucking the tablets.
To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.
To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.
To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests
Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions
Potassium-sparing diuretics: see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility
Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C
Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers
The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use
Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVEROOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE
The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the O-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSAGE AND ADMINISTRATION
The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

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Taking control of MAACs

Wisconsin physicians, like the rest of the nation, have had problems understanding the Medicare Maximum Actual Allowable Charges (MAACs). It has been difficult to understand how to compute MAACs, and even more difficult to resolve computer errors which create incorrect MAACs. But difficult does not mean impossible.

It is important for physicians to realize that they can correct MAAC errors. The bureaucracy is large, but it is possible to work with it. The State Medical Society of Wisconsin has been working closely with WPS-Medicare to help decrease the confusion surrounding MAACs.

The confusion with the MAAC program became clear in November of 1987, when initial MAAC violation notices were mailed to approximately 5% of all physicians throughout the nation. Only 2.5% of Wisconsin physicians received such potential violation notices. This was due, in part, because WPS-Medicare, Wisconsin's Part B Carrier, reviewed each computer generated violation by hand before mailing the notices, and because Wisconsin physicians have kept current on Medicare changes.

It is easy to be confused with the different calculations and profiles used to determine MAACs, and even easier to decide that it is not worth the time or energy to decipher the program. Some physicians have chosen not to raise any Medicare fees, even though an increase may be allowed. Others may be using their customary charges, even though the charges may be higher than their MAAC, and unwittingly overcharging.

The new MAAC regulations that took effect April 1, 1988, however encourage physicians to evaluate their current MAACs and determine if changes need to be made. Physicians are now allowed to use charge data prior to the three-month base period (April-June 1984) for services with MAACs at the 50th percentile level. HCFA now requires physicians to conform to MAACs on every claim because weighted average monitoring will not be used. Therefore, each overcharge can be considered a violation and bring a fine of up to $2,000 per overcharge.

It is now time for physicians to take control of their Medicare MAACs. If physicians have Medicare MAAC problems, they can elicit changes through careful and thorough research. Getting the most out of the system is rarely a simple task, but it may prove to be worth all the effort given. SMS staff will help members correct MAAC problems with WPS-Medicare. The following highlights one Wisconsin physician's efforts to successfully correct his MAACs.

Doctor Jones (not his real name) received his MAAC printout in January 1987. After reviewing it carefully, he discovered several MAAC errors, particularly with his office visit codes:

CPT Code	MAAC
90040	$28.00
90050	42.42
90060	110.10
90070	22.67
90080	66.66

He wrote to WPS-Medicare in April of 1987, stating that his MAACs were obviously in error, and that he would continue to charge his normal fees which had not increased since 1984. WPS-Medicare did not respond to this letter.

In November of 1987 he received

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notice that he was in violation of his MAAC by nearly $3,000, an accumulated total. Doctor Jones wrote a very clear, objective letter to WPS-Medicare explaining that his MAACs were incorrect and that his base period data were wrong, and detailing how the errors could be corrected.

He also contacted the SMS for advice. The basic problem stemmed from the coding practices used in the office during the three-month base period in 1984. The office did not use CPT codes or CPT descriptions when submitting claims to Medicare. Consequently, when WPS-Medicare created the office code MAACs it lumped all of his charges into two codes, 90050 and 90060, giving Doctor Jones the 50th percentile MAAC for office visits 90070 and 90080.

Clearly, this was incorrect. Medicare, however, could not make the necessary changes without further information. WPS-Medicare did not have the patient progress notes to support the 1984 claims. These were needed to prove which level of care was provided for each claim.

At this point, Doctor Jones had to make a decision: either accept this incorrect MAAC profile or expend time and money researching and copying Medicare claims and progress notes from 1984. Doctor Jones took control.

He and his staff spent hours pulling and copying claims and notes for five procedure codes. These were paperclipped and highlighted to show the pertinent information. He attached an explanatory page, describing terminology and abbreviations in the progress notes. The SMS received the first batch of claims on February 12. After SMS staff reviewed and discussed the claims, more claims were pulled and mailed to the SMS on February 24. This information was carried directly to WPS-Medicare.

This story ended happily. On March 4, 1988, Doctor Jones received notification that his MAACs had been changed to his satisfaction.

Learning to understand Medicare claims, reimbursement and MAACs are the first steps to ensuring that physicians receive equitable treatment from the Medicare program. The new MAAC regulations are a double edged sword—they give physicians an opportunity to legitimately increase their MAACs, but they demand exact MAAC compliance. If you have Medicare questions or problems, contact Trish Ramsay, the SMS's Medicare specialist at 1-800-362-9080.■

Loss Prevention Corner

Today's malpractice crisis has evolved through a complex set of social, legal, and professional interactions. Unfortunately, there are no simple solutions to the problems. The SMS Medical Liability Committee has formed a Loss Prevention Subcommittee to help physicians recognize those exposures to liabilities that are within their control, and to manage them while being responsible for the ultimate safety of the patient. While the subcommittee will be researching all areas of loss prevention and risk management, one essential component has already been identified—the need to educate physicians and medical students. This column is the first step toward that goal.

The loss prevention corner will be a regular feature in the *Wisconsin Medical Journal*, with articles on the who, what, when, where, why and how of medical malpractice. These articles will focus on creating a more predictable environment in which to work. We start by discussing what loss prevention really is.

Loss prevention is actually part of the broader concept of risk management. Risk management is an integrated process that deals with pure risk. As a system, it is meant to identify possible exposures to risk and their causes. It establishes a course of action to manage those exposures, identifies those who are or could be responsible for a loss, and provides a feedback system to incorporate new information into the process. Risk management seeks to define and ensure an acceptable process of care within legal confines.

Risk management can be broken down into two distinct areas—loss prevention and loss reduction. Loss prevention focuses on reducing the frequency and/or severity of an identified potential loss before it happens. Loss reduction attempts to reduce the impact of a loss once it occurs. For example, loss prevention uses information about why people sue to reduce the likelihood of future malpractice actions. Loss reduction would, in this case, focus on what can be done after a malpractice action has been started to reduce the economic and emotional impact on the physician and the patient.

Loss prevention is a tool that health care providers need to emphasize to find solutions to the professional liability dilemma. Loss prevention recognizes that a good medical outcome is no guarantee of protection from legal action, nor does every bad result automatically lead to the courtroom. The broad spectrum of causal factors requires physicians to look beyond the acceptable standard of care to subjective factors such as the patient's perception of a physician's style of practice. It is not surprising that 70% of physicians now indicate that they have altered the way they practice medicine to protect against lawsuits

(AMA 1985). Therefore, one loss prevention technique is intended to facilitate positive changes in the physician-patient relationship and to reduce the need for the practice of defensive medicine.

Please send suggestions or submissions for future Loss Prevention Corner articles to Kit Nimtz, Division of Medical Policy and Practice, State Medical Society of Wisconsin, PO Box 1109, Madison, WI 53701.■

Patients pay nursing home bills

Data on expenditures for nursing home care in 1986, according to the Department of Health and Human Services, indicate that of the $31.1 billion in payments, $19.4 billion (51%) came directly from the patients. Payments from third parties came predominantly from Medicaid, representing $15.8 billion (41.4%). Private health insurance totaled only $300 million (0.8%).■

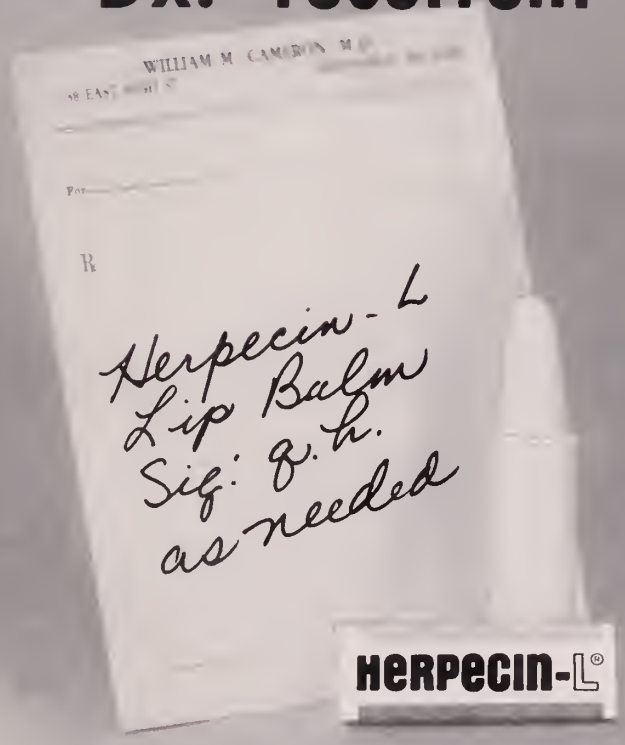
SMS monitors Medigap policy sales

A program co-sponsored by SMS is helping to shed light on dubious sales tactics by insurance agents to a potentially large group of Wisconsin's low-income elderly. Seniors enrolling in PartnerCare, the SMS and Coalition of Wisconsin Aging Groups' voluntary Medicare assignment program, list their Medicare supplemental policy coverage on the program's income verification form. The experience to date indicates that a problem may exist with seniors paying out significant sums for needless, unaffordable insurance policies.

Low-income seniors, fearful of ever-growing gaps in Medicare coverage, are actively purchasing "Medigap" or Medicare supplemental coverage. Medicare supplemental policies entered the market in the 1960s. Their sale in Wisconsin was first regulated by the Office of the Commissioner of Insurance (OCI) in 1977, following a rash of selling abuses. OCI's oversight relaxed soon thereafter, in response to an apparent decline of overzealous and deceptive selling practices. Similar controls imposed in 1981 on the sale of long-term care policies were modified last year. last year.

Consumer concerns, however, have resurfaced with respect to Medigap policies. OCI received 7,567 consumer complaints in 1987, and 893 (about 12%) of them pertained to Medicare supplemental insurance policies. A confluence of factors is at work here: loosened state regulation, high-pressure sales tactics by agents pursuing sizable commissions, and an elderly population at risk for decreased access to care in the face of dwindling Medicare coverage. The result is the current sorry sit-

Dx: recurrent herpes labialis



"HERPECIN-L is my **treatment of choice** for perioral herpes." GP, NY

"HERPECIN-L appears to actually **prevent** the blisters . . . used **soon enough.**" DDS, MN

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"(In clinical trials) . . . **response** was **dramatic. HERPECIN-L** . . proven **far superior.**" DDS, PA

"All patients claimed **shorter duration** . . . at **prodromal symptoms** . . . HERPECIN-L **averted** the attacks." MD, AK

OTC. *See P.D.R.* for information. For samples to make your own clinical evaluation, write: CAMPBELL LABORATORIES, INC., P.O. BOX 812-MD, FDR STATION, NEW YORK, N.Y. 10150

In Wisconsin, HERPECIN-L is available at all *Gerhardt, Osco, Revco, Walgreens, Snyders* and other select pharmacies.

uation, wherein many seniors scrape up meager funds to purchase unnecessary policies.

The growing plight of low-income seniors falling prey to improper selling practices is now capturing public attention. OCI plans to strengthen state laws and regulations concerning insurance policies for the elderly, redouble enforcement actions against dishonest agents, and broaden its consumer education efforts in the area of health insurance.

SMS and the coalition will continue to monitor the incidence of excessive coverage through their collection and analysis of PartnerCare income verification forms. The two organizations will share their general findings with OCI on an ongoing basis.

Elderly consumers may file complaints on insurance practices or receive free purchasing advice through two state offices. OCI employs a full-time staff member to answer questions about insurance policies and handle complaints. The number is 608-266-0103. A toll-free, statewide number is expected to operate soon. In addition, OCI distributes printed consumer information on insurance for senior citizens.

The state Board on Aging and Long-term Care also operates a toll-free Medigap Hotline to counsel senior citizens on Medigap insurance, health maintenance organizations and long-term care insurance. The number is 1-800-242-1060.■

NEWS HIGHLIGHTS

*Physician members of the State Medical Society of Wisconsin

The Howard Young Medical Center, Woodruff, and the Medical College of Wisconsin recently announced their affiliation. Howard Young Medical Center is the first rural hospital among the Medical College's 22 existing affiliates. As part of the agreement, fourth-year medical students and family practice residents will work with staff physicians at Howard Young. In addition, physicians from the Medical College will conduct inservice training for the Howard Young staff.

The Rural Wisconsin Hospital Cooperative in Sauk City has received a grant of $341,658 from the Robert Wood Johnson Foundation to begin a quality assurance and physician's accreditation program for the cooperative's 21 member hospitals.

The American Hospital Association (AHA) recently commended St Croix Valley Memorial Hospital in Polk County for its efforts to control costs and increase productivity. The hospital was awarded the 1987–88 Certificate of Recognition by AHA for participating in the HAS/MONITREND System. MONITREND is a monitoring system offered by AHA's Healthcare Administrative Services (HAS) Division to help hospitals reduce costs while maintaining quality health care services.

St Agnes Hospital's medical staff in Fond du Lac recently elected four new officers to its executive committee. They are: John P McCullough, MD, chief of emergency medicine; Philip E Keller, MD,* chief of family practice; Stephen A Massick, MD,* chief of obstetrics-gynecology; and Brian C Christenson, MD,* chief of psychiatry.■

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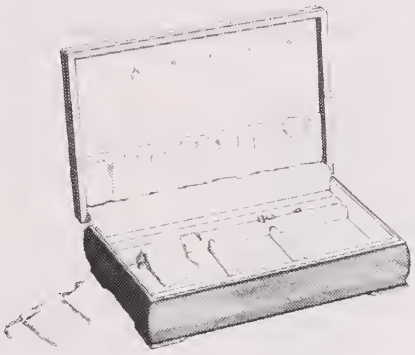
BLUE BOOK/UPDATE

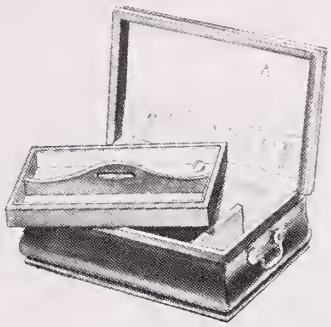
On page 169 of the June 1987 Blue Book issue of the *Journal* under the SMS Committee on Health Care Costs Liaison, Gerald C Kempthorne, MD, Spring Green has resigned. This committee has been renamed to the Committee on Health Care Quality, Costs and Utilization.

On page 168 under the Committee on Environmental and Occupational Health, Susan M Wester, MD, La Crosse, and Jacob Martens, MD, Wausau, have resigned. On page 167 under the SMS Physicians Alliance Commission, Joseph L Teresi, MD, Brookfield, has resigned, and on page 168 under the SMS Commission on Public Information, Douglas G Devan, MD, Kenosha, has resigned. On page 170 under the Committee on Mental Health, Frederick Fosdal, MD, Madison, has resigned.■

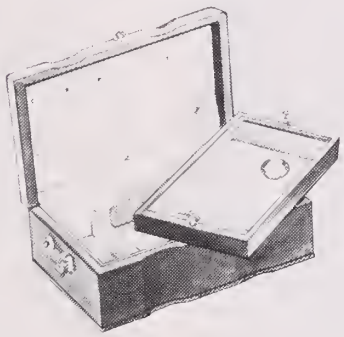
ELEGANT JEWELRY CHESTS FOR HER SPECIAL TREASURES



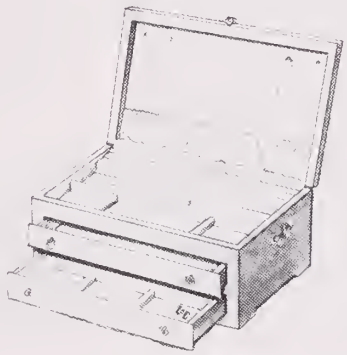
"**Grace**" with two convenient travel pouches. **$55.00.**



"**Old Virginia**" features lift-out tray and antiqued brass-finished side handles. **$85.00.**



"**Princess**" features full-size lift-out tray with handles and brass-finished cover lifts. **$80.00.**



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Study links hospital competition to longer surgical stays

A study reported in the *Journal of the American Medical Association* found a strong association between the number of hospitals in an area and the average length of time patients stay in the hospital after surgery.

Competitive pressures appear to encourage hospitals to accommodate patient and physician preferences for longer lengths of stay, say the authors of the report, James C Robinson, PhD, of the University of California School of Public Health, Berkeley, and colleagues at the University of California School of Medicine, San Francisco.

Their findings suggest that patients, physicians and hospitals will have a difficult time adjusting to the recent changes in reimbursement methods of Medicare and other programs aimed at slowing down the rapid rise in health care costs.

The researchers analyzed data from 747 US hospitals involving 498,454 patients who underwent surgery in 1982, the year before the introduction of Medicare's Prospective Payment System. The study examined 10 different surgical procedures, including intestinal operations, hip replacements, stomach operations and hysterectomies, and was controlled for patient age, sex, and presence of secondary diagnoses and procedures.

The authors found that "hospitals in the most competitive markets reported average lengths of patient stay 16.9 percent higher. . .than comparable hospitals that had no nearby neighbors." The same strong association between competitive pressure and average hospital stay existed for all 10 surgical procedures examined, they report.

"Patients generally prefer longer to shorter postoperative lengths of stay to reduce the subsequent burden of nursing on themselves and family members at home," the authors say. Their findings "are consistent with the hypothesis that patients and physicians tend to prefer longer over shorter lengths of stay for surgical procedures and that hospitals under competitive pressure are more likely to accommodate those desires than hospitals not under such pressure."

According to the authors, the replacement of retrospective by prospective reimbursement methods by Medicare and a variety of Medicaid and private insurance programs, has exerted a dramatic effect on the hospital care marketplace. Because these programs pay a fixed rate per admission within particular diagnostic categories, hospitals that permit longer stays are financially penalized.

Hospitals now face severe economic pressures that limit their ability to compete for patients with costly strategies, such as allowing longer hospital stays. Those, which in the past allowed the longest stays, are being forced to adjust their discharge protocols and to convince their affiliated physicians to also adjust their practice.

"Patients utilizing these hospitals will need to make substantial adjustments in financial and time commitment, given the increasing proportion of total postoperative recovery time that will occur in the home rather than the hospital. The data reported in this study suggest that the adjustment process will be particularly difficult for hospitals, physicians, and patients in competitive local markets, precisely because of the preexisting effects of competition on practice styles," the authors conclude.■

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James H. Sammons, MD
Executive Vice President

American Medical Association 535 North Dearborn Street; Chicago, Illinois 60610

SMS President elected to AMA post

Kenneth M Viste, Jr, MD, president of the State Medical Society, was elected to the American Medical Association's Council on Legislation at the February meeting of the AMA Board of Trustees in Chicago. The council addresses AMA policies that deal with federal legislative issues. The election becomes effective in July.

The council is composed of 10 physicians, one medical resident, one medical student, one member of the American Dental Association and one member of the AMA Auxiliary. Members serve for one year.

In other AMA news of state interest, John K Scott, MD, of Madison was reappointed to the AMA Council on Long-Range Planning, and Kermit L Newcomer, MD, La Crosse, was certified as a candidate for reelection to the AMA Council on Medical Service. Doctor Newcomer is running for a full three-year term on the council.■

SMS President Kenneth M Viste, Jr, MD, (center) accepts a 1987 AMA membership award from William Hotchkiss, MD, (left) and Alan Nelson, MD, (right). The award, presented at the AMA National Leadership Conference in February, recognizes the SMS for increasing its level of AMA membership for the third consecutive year. According to the AMA, Wisconsin has 5,749 paid members compared to a total SMS membership of 6,781.■

Tort task force is up and running

At the first meeting of the SMS Blue Ribbon Task Force, Tillinghast, the nation's premier actuarial company for medical liability insurance, presented a program entitled "Effective Management and Direction of Malpractice Insurers and Trusts." The program covered insurance concepts, how rate changes are calculated, underfunding and tort reform. James Wood, Tillinghast's national professional liablility practice leader, said that the tort reforms that show the most promise of reducing costs are caps on noneconomic damages, limitations on joint and several liability and a shortened statute of limitations. He added, however, that it is generally not advisable for insurers to give rate credits for tort reforms because the amount of savings is uncertain, and if the legislation is subsequently declared unconstitutional, there is a large underfunding problem.

Prior to the Tillinghast presentation, the Blue Ribbon Task Force discussed its goal—to achieve a model alternative to the tort system for medical malpractice. Because of the size of the Task Force and its complex charge, the chairman, Roger L von Heimburg, MD, suggested dividing responsibilities into subcommittees. The following subcommittees were formed:

1) *Fault-based Administrative System,* such as the AMA Specialty Society Project,
2) *No-Fault Compensation System,* such as Workers' Compensation or the Virginia and Florida Birth-Related Neurological Injury acts
3) *Contractual Arrangements-Arbitration,* and
4) *Risk Identification, Allocation and Differentiation.*

The Blue Ribbon Task Force has 14 members. Seven members are physicians and seven are non-physicians:

Roger L von Heimburg, MD, chairman,
William J Listwan, MD,
C Robert Jackson, MD,
Richard G Roberts, MD,
John O Simenstad, MD,

William L Treacy, MD,
Darold A Treffert, MD,
Thomas L Adams, secretary-general manager, SMS
Professor Gordon Baldwin, UW School of Law,
Steve Dickmann, Nelson Industries,
John Duncan, Metropolitan Milwaukee Association of Commerce,
Robert Haase, commissioner of insurance,
Sen David Helbach, and
John Parr, AFCME Council 48.■

AMA Physician's Recognition Award Recipients

LISTED BELOW are those physicians in Wisconsin who have earned the AMA Physician's Recognition Award in recent months. The State Medical Society of Wisconsin congratulates these physicians who have distinguished themselves and their profession by their commitment to continuing education

FEBRUARY 1988

*Collins, Joseph M, Milwaukee
Degala, Satyanarayana V, Tomah
*Doss, Jerry C, Neenah
*Fisher, David R, Madison
*Frase, Louis H, Eau Claire
*Guevara, Esteban, Brown Deer
*Hardacre, Jerry M, Marshfield
Lambrou, Fred H, Shorewood
*Listwan, William J, West Bend
Mayersdorf, Assa, Milwaukee
*Melvin, John L, Milwaukee
*Minikel, Jeffrey L, Milwaukee
*Page, Robert W, Marshfield
*Pagels, George A, Marshfield
*Palmer, Susan K, Brookfield
*Parent, Kevin, Marshfield
*Peterson, Douglas B, Marshfield
*Ravn, Erling O, Merrill
Ray, Jefferson F, Marshfield
Reyes, Cesar N, Marshfield
*Ryan, Michael E, Marshfield
*Schneider, George R, West Allis
*Semler, William L, Milwaukee
*Starling, James R, Madison
*Stemper, John A, Shorewood
*Stoerker, Ruth A, Madison
*Stram, Thomas W, Marshfield
*Unger, Michael J, Menomonee Falls
*Wadhwani, Indur B, Racine
*Wild, Joseph P, Mequon

*Members of the State Medical Society of Wisconsin ■

House to consider resolutions

The House of Delegates will consider resolutions ranging from medical liability issues to environmental concerns when it convenes at the SMS Annual Meeting in Milwaukee, April 28-30.

The following resolutions were submitted to the secretary-general manager's office by the February 24 deadline. The complete resolutions can be found in the Delegate's Handbook. Members are encouraged to express their opinions to their delegates and to participate at the Annual Meeting Reference Committee hearings. A list of the members of the House of Delegates appears elsewhere in this issue.

1—MAAC Discrimination (Bruce A Kraus, MD, delegate, Young Physicians Section). Referred to National Issues.

"RESOLVED, The SMS continue to support and work with AMA and Health Care Financing Administration to correct the discriminatory practice in the implementation of Maximum Allowable Actual Charges."

2—Contract Review and Negotiation Services (Bruce A Kraus, MD, delegate, Young Physicians Section). Referred to Organization and Finances.

"RESOLVED, The SMS study physician need for contract review and negotiation services, and if indicated, take steps to formally provide such services to physicians in Wisconsin through SMS."

3—Claims-made Insurance (Bruce A Kraus, MD, delegate, Young Physicians Section). Referred to Organization and Finance.

"RESOLVED, that the SMS develop an informational brochure that physicians can use when selecting a malpractice carrier; and be it further RESOLVED, that this brochure be available for wide distribution to physicians, especially medical students, residents, young physicians and physicians considering retirement."

4—Consent for Release of Medical Information (Bruce A Kraus, MD, delegate, Young Physicians Section). Referred to Scientific Activities.

"RESOLVED, the SMS work with the Insurance Commissioner to establish a procedure to ensure appropriate release of information procedures to protect the confidentiality of patient information and to allow timely information exchange for insurance and review purposes."

5—Pursuit of Speeders (James S Janowiak, MD, delegate, Lincoln County Medical Society). Referred to Scientific Activities.

"RESOLVED, that the State Medical Society of Wisconsin support legislation prohibiting the pursuit of motor vehicles for traffic law violations if such pursuit leads to excessive speeds or otherwise potentially dangerous conditions; and be it further RESOLVED, that such legislation delegate power to competent law enforcement agencies to initiate action against the owner of the involved vehicle as identified by appropriate procedures."

6—Professional Liability Insurance Tail Coverage (J S Mayersak, MD, president, Lincoln County Medical Society). Referred to Socioeconomic Activities.

"RESOLVED, that the Physicians Insurance Company of Wisconsin include in the insurance coverage, a provision that if a physician has maintained the malpractice insurance period of five years or longer, that no tail coverage buyout is to be required; and be it further RESOLVED, that a financial impact statement regarding the above matter be made available to the officers of State Medical Society of Wisconsin for appropriate distribution to the officers of the county medical societies."

7—Advanced Trauma Life Support (Waukesha County Medical Society). Referred to Scientific Activities.

"RESOLVED that the State Medical Society endorse the Advanced Trauma Life Support sponsored by the Committee on Trauma of the American College of Surgeons to all physicians in Wisconsin and encourage physicians involved in emergency care to take the course."

8—Medicare Reimbursement Equity (Marinette-Florence County Medical Society). Referred to National Issues.

"RESOLVED, that SMS continue to support and work with the AMA, the Wisconsin Congressional delegation, and the Health Care Financing Administration to correct the inequities through legislation and/or regulatory changes in physician reimbursement under the present Medicare system."

9—Professional Liability Legislation 'Cap' (Pierce—St. Croix County Medical Society). Referred to Socioeconomic Activities.

"RESOLVED, that the State Medical Society give high priority during the 1989 Wisconsin Legislature for the enactment of legislation that will limit total recovery for noneconomic damages in medical malpractice lawsuits to $250,000 for both awards and settlements, and will repeal the current sunset of December 31, 1990, on the existing noneconomic damages cap for medical liability awards."

10—Family Planning and Fertilized Ovum (James A Means, MD, District 1 delegate). Referred to National Issues.

"RESOLVED that the State Medical Society assume the scientific position of accepting a fertilized ovum as a human embryo and potentially a human being; and be it further

RESOLVED that the State Medical Society support the position of the US Department of Health and Human Services to the effect that family planning programs receiving federal funds may not provide abortion counseling, may not refer women to abortion providers and may not engage in lobbying or legal action to increase the availability of abortion, and work toward its implementation in the state of Wisconsin."

11—Alcohol in Food Preparation (Monroe County Medical Society). Referred to Scientific Activities.

"RESOLVED, that the State Medical Society support legislation requiring that restaurants specify on the menu when alcohol is used in the preparation of food."

12—Ambient Air Quality (Committee on Environmental and Occupational Health). Referred to National Issues.

continued on page 45

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INDICATIONS AND USAGE: BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis, in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2. For the prevention of potassium depletion when the dietary intake is inadequate in the following conditions: Patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, and with certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS: Potassium supplements are contraindicated in patients with hyperkalemia since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: Chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene).

Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to enlarged left atrium.

All solid dosage forms of potassium chloride supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation.

WARNINGS: Hyperkalemia—In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic. The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction with Potassium Sparing Diuretics—Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene) since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions—Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage or perforation.

K-DUR tablets contain micro-crystalloids which disperse upon disintegration of the tablet. These micro-crystalloids are formulated to provide a controlled release of potassium chloride. The dispersibility of the micro-crystalloids and the controlled release of ions from them are intended to minimize the possibility of a high local concentration near the gastrointestinal mucosa and the ability of the KCl to cause stenosis or ulceration. Other means of accomplishing this (e.g., incorporation of potassium chloride into a wax matrix) have reduced the frequency of such lesions to less than one per 100,000 patient years (compared to 40–50 per 100,000 patient years with enteric-coated potassium chloride) but have not eliminated them. The frequency of GI lesions with K-DUR tablets is, at present, unknown. K-DUR tablets should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis—Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, potassium acetate, or potassium gluconate.

PRECAUTIONS: The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium. The treatment of potassium depletion, particularly in the presence of cardiac disease, renal disease, or acidosis requires careful attention to acid-base balance and appropriate monitoring of serum electrolytes, the electrocardiogram, and the clinical status of the patient.

Laboratory Tests: Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions: Potassium-sparing diuretics: see **WARNINGS**.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C: Animal reproduction studies have not been conducted with K-DUR. It is also not known whether K-DUR can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. K-DUR should be given to a pregnant woman only if clearly needed.

Nursing Mothers: The normal potassium ion content of human milk is about 13 mEq per liter. Since oral potassium becomes part of the body potassium pool, so long as body potassium is not excessive, the contribution of potassium chloride supplementation should have little or no effect on the level in human milk.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: One of the most severe adverse effects is hyperkalemia (see **CONTRAINDICATIONS, WARNINGS,** and **OVERDOSAGE**). There have also been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see **CONTRAINDICATIONS** and **WARNINGS**); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE: The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see **CONTRAINDICATIONS** and **WARNINGS**). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration and characteristic electrocardiographic changes (peaking of T-waves, loss of P-waves, depression of S-T segment, and prolongation of the QT-interval). Late manifestations include muscle-paralysis and cardiovascular collapse from cardiac arrest.

Treatment measures for hyperkalemia include the following:

1. Elimination of foods and medications containing potassium and of potassium-sparing diuretics.
2. Intravenous administration of 300 to 500 ml/hr of 10% dextrose solution containing 10–20 units of insulin per 1,000 ml.
3. Correction of acidosis, if present, with intravenous sodium bicarbonate.
4. Use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia, it should be recalled that in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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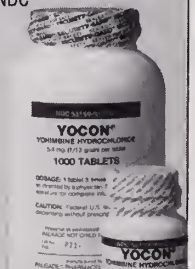

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2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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continued from page 43

"RESOLVED, that the State Medical Society supports the development and rigorous enforcement of hazardous air emissions rules which will prevent adverse effects to human health."

13—Smoke Free Environment in Hospitals and Physicians' Offices (Dane County Medical Society). Referred to National Issues.

"RESOLVED, that the State Medical Society work for the introduction of legislation which would require that hospitals and physicians' offices be maintained as totally smoke-free environments."

14—New Medicare Regulations (Section on Ophthalmology). Referred to National Issues.

"RESOLVED, that the State Medical Society of Wisconsin reaffirms its position that postoperative care is part of the surgical procedure itself and should not be delegated to anyone, except another physician; and be it further

RESOLVED, that the State Medical Society of Wisconsin urge the Health Care Finance Administration of the Department of Health and Human Services of the United States government to permit state PROs to include the providing of postoperative care as a factor which should be included as one of the guidelines used in determining preoperative approval; and be it further

RESOLVED, that the State Medical Society of Wisconsin reaffirms its opposition to all arrangements which encourage referral and re-referral of surgical patients through fee splitting, kickbacks, and other fraudulent acts, particularly where postoperative management compromises the health and safety of the patient; and be it further

RESOLVED, that the House of Delegates of the State Medical Society of Wisconsin instruct the SMS Delegation to the American Medical Association to seek the support and further implementation of the foregoing resolution."

15—HIV Voluntary Test Program (Manitowoc County Medical Society). Referred to Scientific Activities.

"RESOLVED, that it is the policy of the State Medical Society of Wisconsin to request that all patients entering a hospital for surgery or who are likely to become candidates for surgery have a routine voluntary HIV-antibody test as part of their workup; and be it further

RESOLVED, that the HIV-antibody test be employed in the decision-making process regarding the appropriateness of an operation on a patient-candidate; and be it further

RESOLVED, that consideration be given to the patient's antibody status and also the safety of the operative team and other health care workers as part of the equation to help decide how to proceed with the patient treatment plan."

16—State Laboratory of Hygiene (Section of Pathology). Referred to Socioeconomic Activities.

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"RESOLVED, that the State Medical Society work to place a practicing pathologist or other clinical laboratory representative on the Board of the State Laboratory of Hygiene in order to assure that the activities of the Laboratory fulfill its original mandate."

17—Teacher / NATA Certified Trainers (William H Bartlett, MD, Section on Pediatrics). Referred to Scientific Activities.

"RESOLVED, that the State Medical Society of Wisconsin endorse the concept of teacher/NATA (National Athletic Trainers Association) certified trainers for all public and private high schools in Wisconsin as an achievable goal within a time frame of 5 to 10 years."

18—Federal Clean Air Legislation (Committee on Environmental and Occupational Health). Referred to National Issues.

"RESOLVED, that the State Medical Society of Wisconsin and the American Medical Association urge Congress and the President to enact comprehensive clean ambient air legislation without further delay which will lessen risks to human health."

19—Risk Management (David J Matteucci, MD, president, Kenosha County Medical Society). Referred to Socioeconomic Activities.

"RESOLVED, that PIC-Wisconsin, as an example to other insurance companies, be encouraged to start a yearly two or three day course of instructions in how to decrease the incidence of medical malpractice litigation, that a charge be made for the course sufficient to acquire as instructors, people with great teaching ability and appropriate knowledge, that reading material be distributed as part of the yearly course, and that those who attend receive a 10% rebate of their liability insurance costs."

20—Physician Support Groups (David J Matteucci, MD, president, Kenosha County Medical Society). Referred to Socioeconomic Activities.

"RESOLVED, that the SMS form multiple groups of physicians throughout the state whose function it is to counsel the accused physician."

21—Professional Liability—Actuarial Study (David J Matteucci, MD, president, Kenosha County Medical Society). Referred to Socioeconomic Activities.

"RESOLVED, that the actuary of the SMS, list in order based on cost-saving, those areas in which efforts to change the law can be concentrated."

22—Repeal Mandatory Professional Liability Insurance (David J Matteucci, MD, president, Kenosha County Medical Society). Referred to Socioeconomic Activities.

"RESOLVED, that the SMS be directed to file a lawsuit challenging that portion of the malpractice law requiring unlimited liability as a condition of being allowed to work, and that this lawsuit be filed with all due speed."

23—Professional Liability Court Costs and Procedures (David J Matteucci, MD, president, Kenosha County Medical Society). Referred to Socioeconomic Activities.

"RESOLVED, that the SMS support a shift in the cost of medical malpractice insurance toward the trial attorneys by:

a) Supporting an increase in the charge for records sent to attorneys,

b) Supporting an increase in the charge for depositions for trial attorneys, and

c) Supporting an increase in the charge for physician testimony at trials."

24—Insurance Company Reserves (David J Matteucci, MD, president, Kenosha County Medical Society). Referred to Socioeconomic Activities.

"RESOLVED, that the SMS use all means and tactics available to change the law and allow WHCLIP, PIC-W, other medical malpractice insurance companies, and the Fund, to pay judgments out of accumulated funds, and when those funds are expended, to allow losses to be funded on a yearly basis at the amount where yearly premiums reflect yearly payout."

25—Frivolous Lawsuits (David J Matteucci, MD, president, Kenosha County Medical Society). Referred to Socioeconomic Activities.

"RESOLVED, that the SMS support a requirement that defense attorneys agree to pursue legal action against plaintiff's attorneys who file a case where the plaintiff's attorney knew or should have known that the case was frivolous —provided that the physician defendant will himself pay for that lawsuit."

26—Due Process—Bureau of Quality Compliance (Jeffrey K Polzin, MD, Tri-County Medical Society) Referred to Socioeconomic Activities.

"RESOLVED, that 1) the due process procedures governing the Bureau of Quality Compliance of the Department of Health and Social Services be investigated and redefined so that opportunity is provided for medical staff and other appropriate hospital representatives to evaluate and appeal unfavorable findings, 2) the time allowance for appeal be appropriate to the severity of the alleged shortcomings, and 3) that the hospital responses to the shortcomings be received prior to, and included with, any public announcement of such unfavorable findings."

27—Location—SMS Committee Meetings (Emil B Steinke, MD, president of the Rusk County Medical Society). Referred to Organization and Finances.

"RESOLVED, that when committee membership dictates, the State Medical Society of Wisconsin implement a meeting policy wherein a small percentage of the Society's activities are conducted in communities in the northern half of the state as one method of encouraging greater participation by northern Wisconsin physicians and jointly sharing the experiences of both urban and rural medicine among its members, providing the cost does not exceed $5000/year."

28—Physician's Right of Refusal (Manitowoc County Medical Society). Referred to Scientific Activities.

"RESOLVED, that the State Medical Society of Wisconsin should continue to support the voluntary physician/patient relationship which includes the right whereby the patient may leave the private physician at any time and the phy-

sician is similarly free to determine without penalty whether he wishes to form a relationship with a patient or sever an existing relationship; and be it further

RESOLVED, that the State Medical Society of Wisconsin should actively oppose any attempt to amend or alter this concept by any Wisconsin state agency, legislative, licensing, or other body."

29—Uniform Definition of Experimental Procedures and Therapies (Donald A Wollheim, MD, Public Education Committee, Medical Society of Milwaukee County). Referred to Socioeconomic Activities.

"RESOLVED, that the State Medical Society will work with the Office of the Commissioner of Insurance, and other appropriate parties, to develop a uniform definition for experimental therapies and procedures and that a central clearinghouse be established so that all who inquire may learn the status of a therapy or procedure; and be it further

RESOLVED, that any treatment or procedure not officially recognized as experimental, will be considered reimbursable."

30—Managed Health Plans and Full Disclosure of Incentives and Restrictions on Care (John E Whitcomb, MD, Emergency Medical Services Committee, Medical Society of Milwaukee County). Referred to National Issues.

"RESOLVED, that the State Medical Society define the ethical issues of financial incentives for restricting or limiting access to care in managed health plans."

31—Criteria for Public Safety (John E Whitcomb, MD, Emergency Medical Services Committee, Medical Society of Milwaukee County). Referred to Scientific Activities.

"RESOLVED, that the State Medical society develop 'Criteria for Public Safety' at major public events throughout Wisconsin and that such criteria include adequate staffing by appropriate emergency medical personnel and should include arrangements with appropriate local institutions for the provision of emergency care and that such criteria include means of cancellation-postponement of events under circumstances dangerous by accepted national standards to the participants in such event; and be it further

RESOLVED, that such criteria be published and distributed to all producers of public events for their guidance and advice."

32—Permits for Disabled (Marcia J S Richards, MD, Medical Society of Milwaukee County). Referred to Socioeconomic Activities.

"RESOLVED, that the State Medical Society facilitate an alteration in the State of Wisconsin's administrative code to assure the temporary issuance of disabled permits* in a patient's home locality on an instantaneous basis."

(***Editor's note:** this refers to driving permits.)

33—Geographical Criteria for Reimbursement (Donn D Fuhrmann, MD, secretary, Waupaca County Medical Society). Referred to National Issues.

"RESOLVED, that the State Medical Society of Wisconsin will make every effort to convince state and federal legislators and third-party insurance carriers to eliminate geographical criteria for reimbursement to health care providers."

34—Health Insurance Coverage for Infertility (John S Harris, MD). Referred to Socioeconomic Activities.

"RESOLVED, that the State Medical Society support efforts to legislate insurance coverage for the investigation and treatment of infertility problems."

35—Election of President-Elect (M S Blumenthal, MD, Green County Medical Society). Referred to Organization and Finance.

"RESOLVED, that Article IX of the State Medical Society Constitution be amended to provide for the election of the president-elect by the House of Delegates by ballot between at least two (2) candidates."■

*Physician members of the State Medical Society of Wisconsin

PHYSICIAN BRIEFS

Theodore Eric Haglund, MD,* recently joined Philipp H Marty, MD,* at the Blanchardville branch of the Monroe Clinic. A native of Ishpeming, MI, Doctor Haglung graduated from the University of Minnesota in 1977. He completed his internship and residency at Bristol Memorial Hospital in Bristol, TN.

John K Scott, MD,* of Madison has been reappointed to the AMA Council on Long-Range Planning, and Kermit L Newcomer, MD,* of La Crosse has been certified as a candidate for reelection to the AMA Council on Medical Service; Doctor Newcomer is running for a full three-year term on the Council. These selections took place at the February meeting of the AMA Board of Trustees in Chicago February 12.

Balraju Gandhavadi, MD, of Milwaukee was recently appointed chief of staff at Sacred Heart Rehabilitation Hospital. An assistant professor in the Department of Physical Medicine and Rehabilitation at the Medical College of Wisconsin, Doctor Gandhavadi has been with Sacred Heart since 1979.

Alvin T Grundahl, MD,* recently retired after 42 years of practice in West Bend. Doctor Grundahl graduated from the University of Iowa Medical School and served his internship at Denver General Hospital.

John C Strickler, MD,* recently was appointed emergency room physician for the Sauk Prairie Memorial Hospital. A family practice specialist, Doctor Strickler graduated from the University of Minnesota and completed his residency in Pueblo, CO.

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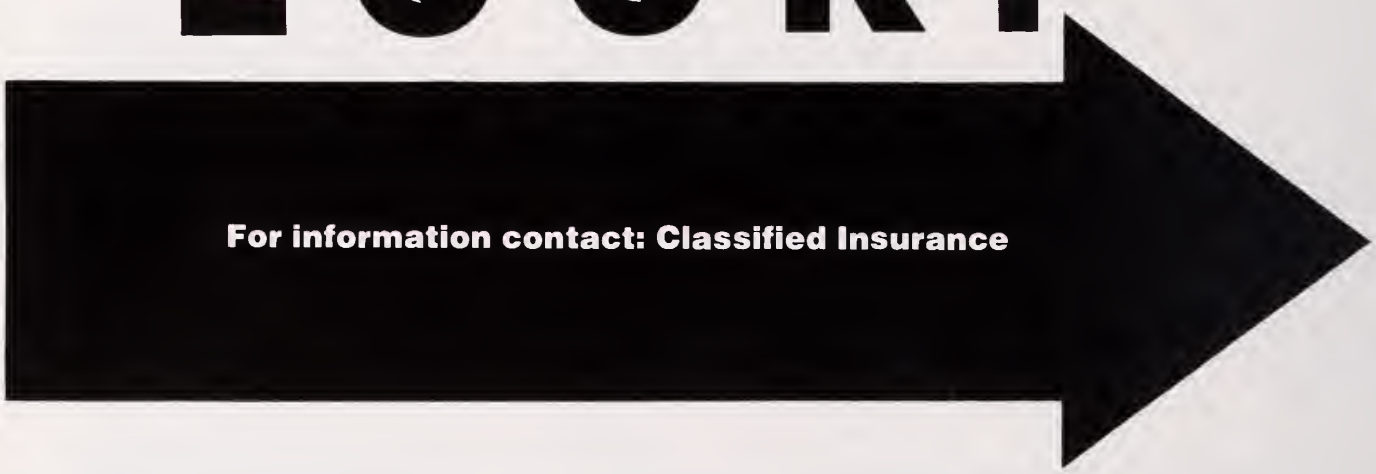

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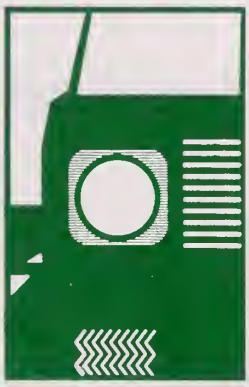

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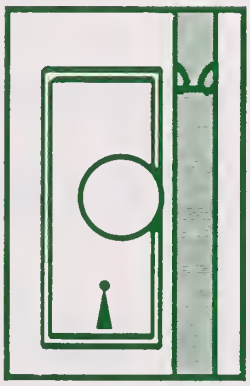

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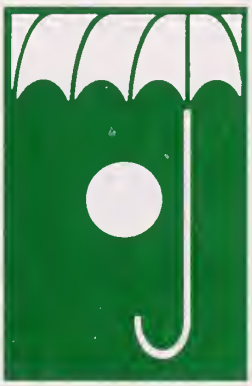

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C I C

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He was previously in private practice in Mineral Point.

James R Fonk, MD,* Wauwatosa, recently was named medical director of Association Life Insurance Company Inc, Brookfield. A specialist in internal medicine, Doctor Fonk has been with Harwood Medical Associates in Wauwatosa for 14 years. He graduated from the Marquette University Medical School and is Board-certified by the American Board of Internal Medicine.

Vijay K Beri, MD,* of Sheboygan was recently recertified as a diplomate of the American Board of Allergy and Immunology. A native of Delhi, India, Doctor Beri graduated from the Medical College in Rohtak, India, where he also completed his internship and residency. He also completed residencies at Grant Hospital in Chicago, Kingsbrook Jewish Medical Center in Brooklyn, NY, and Englewood Hospital in New Jersey.

Wayne W Charland, MD, recently joined St Michael's Hospital in Stevens Point. Doctor Charland previously was a pathologist and lab director at Calumet Public Hospital, Laurium, MI. He graduated from the University of Health Sciences Chicago Medical School and interned at St Mary's and Fairview hospitals in Minneapolis. He served residencies at St Paul Ramsey Hospital in St Paul and Presbyterian Medical Center in Denver.

Peter W Timmermans, MD,* of Waupun recently joined the medical staff at St Agnes Hospital, Fond du Lac. Doctor Timmermans graduated from the University of Western Ontario and is a fellow with the American College of Family Practice.

Frank E Gloss, MD,* of Burlington and James R Dyreby, Jr, MD,* of Rhinelander were recently inducted as fellows of the American Academy of Orthopaedic Surgeons during ceremonies at the association's 55th annual meeting in Atlanta.

Teresita U Romano, MD, of Wild Rose recently joined the Wild Rose Clinic and Waushara Doctors Clinic in Wautoma. She was previously with the Wisconsin Veterans Home in King.

Mark Splaingard, MD, Wauwatosa, was recently appointed medical director of Rehabilitative Services at Children's Hospital of Wisconsin. He is an assistant professor of pediatrics and physical medicine and rehabilitation at the Medical College of Wisconsin.

Kathryn Ann Phyfer, MD, recently joined the medical staff of Hartford-Parkview Clinic in Hartford. She is a diplomate of the American Board of Family Practice and is also on staff at Hartford Memorial Hospital.■

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State Medical Society of Wisconsin

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	Daniel F Johnson	Vacancy
PIERCE-ST. CROIX	Joseph E Powell	James R Beix
POLK	John O Simenstad	William W Young
RUSK	Howard T Chatterton	Douglas M De Long
EIGHTH DISTRICT		
ASHLAND-BAYFIELD-IRON	Charles R Longstreth	John C Oujiri
DOUGLAS	Clarence M Scott	Vacancy
SAWYER	Lloyd M Baertsch	Paul Strapon III

SECTIONS	Delegate	Alternate
Allergy & Clinical Immunology	Marshall E Cusic	Robert J Kriz
Anesthesiology	Warren J Holtey	John H Barsch
Cardiology	D Joe Freeman	Robert M Green
Dermatology	Joel E Taxman	Nyles R Eskritt
Emergency Medicine	Thomas J Luetzow	Jonathan Robinson
Family Physicians	Robert S Viel	Thomas H Peterson
Hospital Medical Staff	Stephen R Peters	Louis R Pfeiffer
Internal Medicine	Les Harrison	Vacancy
Medical Faculties	Mark J Ciccantelli	Manucher J Javid
Medical Students	John M Keggi	Vacancy
Neurology	R Clarke Danforth	Gamber F Tegtmeyer Jr
Neurosurgery	Glenn A Meyer	S Marshall Cushman Jr
Obstetrics-Gynecology	Charles Hammond	Michael A Schellpfeffer
Ophthalmology	M Thomas Chemotti	Gregory P Kwasny
Orthopedics	James M Huffer	David D Mellencamp
Otolaryngology	Glenn M Seager	Thomas W Grossman
Pathology	Raymond C Zastrow	Vacancy
Pediatrics	Carl S L Eisenberg	Vacancy
Physical Medicine & Rehabilitation	William J La Joie	Ram Parvesh Bhala
Plastic Surgery	Sharon L Elias	Terrence J Wilkins
Preventive Medicine	Constantine Panagis	Jane A Kilsdonk
Psychiatry	Rudolf W Link	Vacancy
Radiation Oncology	Robert H Greenlaw	Sally M Schlise
Radiology	Timothy T Flaherty	Ivan Knezevic
Resident Physicians	Vacancy	Vacancy
Surgery	Louis C Bernhardt	Dean B Pratt
Urology	Stuart W Fine	Charles W Troup
Young Physicians	Bruce A Kraus	Laura J Mueller

PRESIDENTS' RECEPTION AND DINNER • THURSDAY, APRIL 28, 1988

State Medical Society of Wisconsin President Kenneth M Viste Jr, MD and Auxiliary President Barbara Newcomer invite members to spend the evening enjoying the innovative five-piece jazz band called NEO following the Annual Meeting dinner at the Regency Room, second level of the Hyatt-Regency, Milwaukee. Reception starts at 7:00 pm followed by the dinner at 8:00 pm.■

SUMMARY OF EVENTS: 1988 Annual Meeting, Thursday-Friday-Saturday, April 28-29-30

Thursday, April 28

7:00 am
District I Caucus

7:00 am–8:00 am
District II Caucus

7:30 am–4:00 pm
Auxiliary Registration
House of Delegates

8:00 am
SMS Section Delegates Caucus

8:00 am–9:00 am
Young Physicians Section Caucus Breakfast Meeting

8:00 am
Registration
House of Delegates

9:00 am
First Session
House of Delegates

9:00 am
Auxiliary House of Delegates

11:30 am
Committee on Alcoholism and other Drug Abuse and Auxiliary luncheon program

11:45 am
Charitable, Educational, Scientific luncheon

12:00 pm–1:00 pm
Reference Committee Luncheon

1:00 pm
Reference committees

1:30 pm–4:00 pm
Committee on Aging and Extended Care Facility

2:00 pm
Auxiliary House of Delegates

4:00 pm–5:00 pm
WISPAC Board of Directors Meeting

4:00 pm–5:30 pm
Auxiliary New Board Orientation

4:00 pm–5:30 pm
Auxiliary Pin and Gavel Club

4:00 pm–5:30 pm
Commission on Continuing Medical Education–Directors of Medical Education meeting/reception

6:00 pm–7:00 pm
WISPAC Reception

7:00 pm
Presidents' reception

8:00 pm
Presidents' dinner

Friday, April 29

7:00 am
Medicine and Religion breakfast

8:00 am–9:00 am
Young Physicians Section Caucus Breakfast Meeting

8:40 am–11:40 am
Preventive Medicine Program

8:40 am–11:40 am
Sexually Transmitted Infectious Disease (panel)

9:00 am–3:30 pm
Emergency Medicine and American College of Physicians program

9:00 am
District I Caucus

9:00 am–10:00 am
District II Caucus

9:00 am
Auxiliary House of Delegates

9:00 am–11:30 am
Family Medicine Program

10:00 am–11:30 am
Medical Liability Committee program

10:00 am–11:30 am
Wisconsin Nursing Association Liaison Committee program

11:30 am
Auxiliary Inaugural luncheon

11:45 am
Socioeconomic/WisPac luncheon/program

1:00 pm
House of Delegates registration

1:00 pm–5:00 pm
Plastic Surgery program

1:30 pm–5:00 pm
Psychiatry and Mental Health Committee program

1:45 pm–5:00 pm
Second and Third Sessions, House of Delegates

1:45 pm–4:15 pm
Primary Care and Office Orthopaedics (panel)

4:30 pm–5:30 pm
Joint Annual Meeting with Wisconsin Society of Preventive Medicine and Preventive Medicine Section

6:00 pm
Past Presidents; reception and dinner

6:30 pm
Wisconsin Society of Internal Medicine dinner

6:30 pm
Wisconsin Society of Plastic Surgeons dinner

6:30 pm–9:15 pm
Women Physicians & Women in Medicine dinner/program

Saturday, April 30

7:30 am–9:00 am
AMA Breakfast

7:30 am–1:00 pm
Otolaryngology program

8:15 am
SMS Board of Directors breakfast meeting

8:30 am–12:30 pm
Anesthesiology program

9:00 am–11:45 am
Internal Medicine and American College of Physicians program

9:00 am–4:00 pm
Pathology program

9:00 am–11:45 am
Endocrine (panel)

10:00 am–12:00 noon
Radiation Oncology program

12:15 pm–4:00 pm
Allergy and Clinical Immunology program

12:30 pm–3:00 pm
Wisconsin Society of Internal Medicine Council luncheon meeting

1:00 pm–4:30 pm
Dermatology program

1:15 pm–4:30 pm
Physical Medicine and Rehabilitation program

1:30 pm–5:00 pm
Surgery program

6:00 pm–7:00 pm
Wisconsin Surgical Society dinner.■

COUNTY SOCIETIES

BROWN: Thirty-two members were present at the February meeting of the Brown County Medical Society to hear Thomas L Adams, Secretary/General Manager of the State Medical Society of Wisconsin speak on the "State Medical Society, 1988." Michael J Meyer, MD,* De Pere, was elected a member of the Society.

FOND DU LAC: At the January meeting of the Fond du Lac County Medical Society, William J Listwan, MD,* West Bend, spoke on "Medical Liability Within the State of Wisconsin," and Herbert F Sandmire, MD,* Green Bay, spoke on the "Coalition for Fairness in Medical Litigation and Tort Reform."

OUTAGAMIE: Twelve members were present at the January meeting of the Outagamie County Medical Society. Fred H Koenecke, Jr, MD,* Madison, who belongs to the advisory committee of the SMS Committee on Alcoholism and Other Drug Abuse, spoke on "Chemical Dependency and Depression." Gerald R Mich, MD,* Appleton, presented a resolution on removing smoke and smokeless tobacco from the Appleton schools, and the resolution was passed. The 1988 delegates from Outagamie County Medical Society to the State Medical Society were elected, and they are MDs David R Finch,* Henry Chessin,* Charles F Dungar,* and C William Freeby* all of Appleton.

RUSK: Richard Bergenstal, MD, from the International Diabetic Center in Minneapolis, MN, one of the guest speakers at the January meeting of the Rusk County Medical Society, spoke on "Update on Diabetes." The other guest speaker, Linda Rasmussen, professor of social work at Mt Senario College, spoke on "Love: The Las Vegas Experience." Nine members and guests were present. Mr Tom Stoebig, Assistant Manager of Medical Society Relations of the Division of Public Affairs of SMS, requested and received unanimous endorsement of PartnerCare from the Rusk County Medical Society. Howard T Chatterton, MD,* Ladysmith, presented a resolution that the State Medical Society periodically hold their annual meetings in the northern part of the state, thereby encouraging and facilitating the presence of physicians that practice in the northern half of Wisconsin. The resolution will be voted upon at the SMS Annual Meeting held in Milwaukee later this month.

WAUKESHA: At the February meeting of the Waukesha County Medical Society held in Brookfield, the following MDs were accepted to membership in the Society. They are Lynn Schallberg,* Diane M Goetz* from Waukesha, and transfers from the Medical Society of Milwaukee County are Lynn A DiUlio,* Waukesha, Lawrence L Foster,* Brookfield, Michael Phillips,* Oconomowoc, and Richard M Schaefer* from Elm Grove.

WINNEBAGO: Thirty-three members and one guest were present at the February meeting of the Winnebago County Medical Society. Guest speaker was David J Beste, MD, Menomonee Falls, who spoke on "What's New in Otitis Media."■

OBITUARIES

Elmore P Huth, MD, 79, former Wauwatosa physician, died Dec 15, 1987 in Englewood, FL. Born Jan 23, 1908 in Milwaukee, Doctor Huth graduated from Marquette University School of Medicine and served an internship at St Joseph's Hospital, Milwaukee. His residency was completed at St Michael's Hospital in Milwaukee and a surgery residency was completed at the University of Pennsylvania. He retired from medical practice in 1962. He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association. Surviving are his widow, Leone and one daughter, Diane Drott, and one son, Terry of Wauwatosa.

Kevin P Wong, MD, 34, Menominee, died Dec 23, 1987 in Green Bay. Born May 21, 1953 in Hong Kong, Doctor Wong graduated from the University of Indiana School of Medicine, and completed his pediatric residency at Riley's Children Hospital and Indiana University in Indianapolis. Doctor Wong had been on the medical staff of the Marinette-Menominee Medical Center. Surviving are his parents of Hong Kong, and seven brothers and sisters.

John O Grade, MD, 63, Elm Grove, died Dec 30, 1987 in Elm Grove. Born Aug 8, 1924 in Menasha, Doctor Grade graduated from Marquette University School of Medicine and completed his residency at St Joseph's Hospital in Milwaukee. Doctor Grade had practiced medicine in Elm Grove since 1948. He was a past president of the Wisconsin Academy of Family Physicians and was an alternate delegate of the American Academy of

Family Physicians. He was chairman of the Department of Family Practice at St Joseph's Hospital and former chairman at Elmbrook Memorial Hospital. He was a member of Waukesha County Medical Society, State Medical Society of Wisconsin, and American Medical Association. Surviving are his widow, Shirley; six sons, Sam, Minneapolis, MN; Doctor Tom, Milwaukee; Doctor Matt, Mazomanie; Ben, Andrew, a student at The Medical College of Wisconsin, Milwaukee; Charles, a junior at the University of Wisconsin Medical School, Madison; and four daughters, JoAnn Rienstra, Port Townsend, WA; Doctor Peggy, CA, a psychologist; Mary, RN, Milwaukee and Jean of Madison.

William J Focke, MD, 90, Poynette, died Jan 3, 1988 in Poynette. Born June 16, 1897 in Chicago, IL, Doctor Focke graduated from the University of Illinois College of Medicine, Chicago, and served his internship at City and County Hospital, St Paul, MN. Doctor Focke had practiced medicine in Poynette for 65 years. He was one of the University of Wisconsin Medical School's original faculty members when it began a four-year medical degree program in 1925. He was a member of the Dane County Medical Society, State Medical Society of Wisconsin, and American Medical Association. Surviving are two daughters, Maurine McCreedy of Oostburg and Manetta Merrill of Poynette.

Richard W Ashley, MD, 73, Kenosha, died Jan 4, 1988 in Kenosha. Born June 17, 1914 in Kenosha, Doctor Ashley graduated from the University of Michigan Medical School, Ann Arbor, and served an internship at St Luke's Hospital in Chicago. His residency in ophthalmology was completed at Billings Presbyterian Hospital in Montana. He served from 1941-1945 in the United States Army Medical Corps. Doctor Ashley had his medical practice in Kenosha since 1945. He was former chief-of-staff of Kenosha Hospital and Medical Center and on the medical staff of St Catherine's Hospital. He was a member and past president of the Kenosha County Medical Society, a member of the State Medical Society of Wisconsin and American Medical Association. Surviving are his widow, Mary; three sons, Richard W, Winnetka, IL; Dr Charles M, Kenosha, and John R, Brown Deer; a stepson, Richard P Frost, Coeur d'Alene, ID; four daughters, Audrey Kovacic, Rye, NY; Allyson Junkel, Ottawa, IL; Anne Mater, Brookfield; Alaine Gomez, Hingham, MA; and two stepdaughters, Judith Russert, Cincinnati, OH, and Patricia Callahan of Kenosha.

Lee Edward Miller, MD, 78, Wauwatosa, died Jan 11, 1988 in Milwaukee. Born Sept 16, 1910 in Tacoma, WA, Doctor Miller graduated from Northwestern University Medical School and completed his internship at Milwaukee Lutheran Hospital. He served in the United States Army Medical Corps from 1940-1945. Doctor Miller had his medical practice in West Allis for 45 years before retiring in 1986. He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association. Surviving are his widow, Barbara; three sons, Richard of Texas; David, Cedarburg; Steven, Milwaukee; and three daughters, Lea Ellen, Texas; Peggy, Indiana; and Mary Lynn of Milwaukee.

Charles L Qualls, MD, 78, Beaver Dam, died Jan 15, 1988 in Beaver Dam. Born Oct 22, 1909 in Dexter, MO, Doctor Qualls graduated from Loyola University School of Medicine, Chicago, IL, and completed his internship at St Agnes Hospital in Fond du Lac. He served in the United States Army Medical Corps from 1941-1946. Doctor Qualls began his medical practice in Beaver Dam in 1946. In 1986 he became a member of the "50 Year Club" of the State Medical Society of Wisconsin. He was a member of Dodge County Medical Society and American Medical Association. Surviving are his widow, Virginia; one son, Brandon, Providence, RI, and one daughter, Gail Van Every of Alexandria, VA.

Roy B Larsen, MD, 73, Wausau, president of the State Medical Society of Wisconsin, 1977-1978, died Jan 22, 1988 in Wausau. Born Nov 4, 1914 in Denmark, WI, Doctor Larsen graduated from the University of Wisconsin, Madison, and completed his residency at the University of Wisconsin Hospital. He had a surgical medical practice in Wausau from 1948-1962 when he became founding member of the Wausau Medical Center. He served as its president in 1966 and also was on the Board of Directors. He was on the SMS Board of Directors and Executive Committee from 1976-1979 and served as president of SMS in 1977-1978. In 1974 he became vice president and medical director of Wausau Insurance Companies and retired in 1984. In 1978 Doctor Larsen was presented the Max Fox Preceptor Award for excellence in teaching UW medical students. In 1981 he became president of the A Ward Ford Memorial Institute, having served as its medical director and as a member of its Board of Trustees. He was a member and former president of the Marathon County Medical Society and also a member of the American Medical Association. Surviving are one daughter, Kristi, Oshkosh; three sons, Peter, Palatine, IL; Trygve, Madison; and Eric of Sacramento, CA.

Walter J Urben, MD, 82, Madison, died Jan 28, 1988 in Madison. Born Feb 7, 1905 in Monticello, Doctor Urben graduated from the University of Wisconsin Medical School, Madison, and served his internship at Ancker Hospital, St Paul, MN. After his internship, Doctor Urben worked in state and private mental hospitals in Ohio for nine years. In 1940 he became a staff physician at Mendota State Hospital, and in 1943 he left the hospital to become director of the State Division of Mental Hygiene. In 1948 he resigned and became superintendent of Mendota State Hospital until his retirement in 1970. Doctor Urben was a life fellow of the American Psychiatric Association, a member of the Wisconsin Psychiatric

Association, the Milwaukee Neuro-Psychiatric Society, Dane County Medical Society, State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Anita; three sons, John, Oregon; Noel, New York City; and David of San Diego, CA.■

1988 ANNUAL MEETING
STATE MEDICAL SOCIETY OF WISCONSIN
AT THE MECCA, MILWAUKEE (Hyatt Hotel) • APRIL 28–30

Kathy Belgea, MD, Scientific Program Chairman, assisted by Charles Holmburg, MD, Menomonee Falls; George Nemec, MD, Woodruff; and Thomas Meyer, MD, Madison

Membership Directory—Update

The following information is being provided from Membership reports and from individual members for updating the 1987 Membership Directory as published in the July 1987 issue of the *Wisconsin Medical Journal*. Because of space limitations address changes and phone numbers will not be included in this Update; however, they will be changed in Membership Records. County transfers will be included when processing has been completed by Membership Records. **Changes in practice specialties** (as used by the AMA) and changes in **Board-certified specialties** as listed by the American Board of Medical Specialties (see July 1987 Membership Directory) are included. **Practice specialties** appear before the slash (/) and **Board-certified specialties** appear after the slash.

By County Society

BARRON/WASHBURN/BURNETT

FP/FP
Mary A Ocwieja MD
1020 Lakeshore Dr
Rice Lake WI 54868

BROWN

FP
Michael J Meyer MD
301 N Broadway
De Pere WI 54115

FP
Robert J Stevens MD
1751 Deckner Ave
Green Bay WI 54302

FP/FP
Mark K Villwock MD
1751 Deckner Ave
Green Bay WI 54302

DANE

IM
Mary Q Burke MD
6 Longmeadow Circle
Madison WI 53717

PS GS/GS
John A Butler MD
2818 McKenna Blvd
Madison WI 53719

ID IM/IM
Brian T Courtney MD
4501 Jenewein Rd
Fitchburg WI 53711

John H Danner III
409 N Eau Claire Ave, #315
Madison WI 53705

P
Krishna Dasgupta MD
3306 Blackhawk Dr
Madison WI 53705

Tracy David
2143 University Ave, #2
Madison WI 53705

Mary K Ellis MD
2640 Stevens St, #1
Madison WI 53705

FP/FP
Gaspar Giorgi MD
5401 Marsh Rd
Madison WI 53704

Emily Gray
1115 Chandler St, #4
Madison WI 53715

Brian A Hebl
1157 Observatory Rd
Belleville WI 53508

IM CD/IM
Edwin F McNichols MD
5530 M-H Townline Rd
Milton WI 53563

Paul J Ruh
2606 High Ridge Trail
Madison WI 53713

Dale R Rustad
1606 Wildoak Cir
Madison WI 53713

GS ON/GS
Frederick K Storm III MD
6302 Sleepy Hollow Cir
Middleton, WI 53562

Michael C Struck
7662 Carrington Dr, #C
Madison WI 53719

DOUGLAS

Robert R Mataczynski MD
1514 Ogden Ave
Superior WI 54880

JEFFERSON

GS
Beth E Hothan-Zielinski MD
630 Rogers St
Fort Atkinson WI 53538

LA CROSSE

GE IM/GI
Frank J Aberger MD
1836 South Ave
La Crosse WI 54601

FP
Laura L Bloomquist MD
700 West Avenue South
La Crosse WI 54601

FP/FP
Dennis G Greer MD
815 South 10th St
La Crosse WI 54601

CDS IM/CDS
Bruce Handler MD
1836 South Ave
La Crosse WI 54601

MARATHON

VS/GS
Sally S Mattingly MD
425 Pine Ridge Blvd, #203
Wausau WI 54401

CDS IM/IM
David K Murdock MD
425 Pine Ridge Blvd, #205
Wausau WI 54401

MILWAUKEE

FP
Ramon A Agor MD
2711 West Wells
Milwaukee WI 53208

EM
Edward N Barthell MD
11348 N Laguna Dr
Mequon WI 53902

PD OS/PD
Bonnie-Jo G Bates MD
2600 N Mayfair Rd
Milwaukee, WI 53226

EM
Cynthia A W Bauer, MD
3318 S 119th St
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ORS
Michael J Brennan MD
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Milwaukee WI 53226

OBG GO/OBG
Herbert J Buchsbaum MD
8700 W Wisconsin Ave
Milwaukee WI 53226

GP
Richard P Cramer MD
8410 W Cleveland Ave
West Allis WI 53227

Patrick A Dowling
3139A N 55th St
Milwaukee WI 53216

PD CHN
J Robert Flamini MD
4441 N 103rd St, #8
Milwaukee WI 53225

IM/IM
Michael R Fehrer MD
8105 W Lisbon Ave
Milwaukee WI 53222

Michael S Goldstone MD
2556 North 69th St
Milwaukee WI 53213

Tami L Hellenbrand MD
2866 North 50th St
Milwaukee WI 53210

David J Hetzel
3641 North 41st St
Milwaukee WI 53216

IM
Andrew S Krock MD
3003 W Good Hope Rd
Milwaukee WI 53217

Michael Kushnaryov MD
5434 W Capitol Dr
Milwaukee WI 53216

P
Craig Larson MD
509 W Wisconsin Ave
Milwaukee WI 53203

IM
Romeo C Lo MD
3660 N Teutonia Ave
Milwaukee WI 53216

PTH GP
Luz S Moreno MD
100 E Cherokee Cir
Fox Point WI 53217

P/P
Arvind G Phansalkar MD
2435 Byron Ct
Brookfield WI 53226

AN
Tapati Ray MD
18905 Tavala Dr
Brookfield WI 53005

Anthony L Russo
16005 Mark Dr
Brookfield WI 53005

CDS IM
James W Vetter MD
PO Box 26509
Milwaukee WI 53226

David R Weaver DO
5434 W Capitol Dr
Milwaukee WI 53216

PORTAGE

GP
Kathleen J McGinnis MD
2501 Main St
Stevens Point WI 54481

RACINE

Richard J Fogle MD
3719 Wyoming Way
Racine WI 53404

IM
Daniel B Ross MD
5625 Washington Ave
Racine WI 53406

IM
Thomas E Vravick MD
16 N Western Ave
Park Ridge IL 60068

R
Walter Wong MD
1320 Wisconsin Ave
Racine WI 53403

Thomas W Wood MD
5625 Washington Ave
Racine WI 53406

TREMPEALEAU/JACKSON/BUFFALO

FP/FP
Charlotte A Clark MD
PO Box 297
Whitehall WI 54773

FP/FP
Gary Petersen MD
610 West Adams St
Black River Falls WI 54615

VERNON

GP
William N Calkins MD
100 Melby
Westby WI 54667

P/P
David A Van Dyke MD
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Viroqua WI 54665

WAUKESHA

GS
Robert S Monk MD
217 Wisconsin Ave
Waukesha WI 53186

PD/PD
Lynn F Shallberg MD
N14 S23900 Stoneridge
Waukesha WI 53188

WINNEBAGO

P
Mahmoud M Ahmed, MD
610 Starboard Ct, #D
Oshkosh, WI 54901

EM FP/FP
Jill P Harman MD
1925 Nates Ct
Neenah WI 54956

PD ID/PD
Bashar F Kayali MD
1951 Bowen St
Oshkosh WI 54901

NEP IM/IM
Michael A Madden MD
515 Broad St
Menasha WI 54952

P
Ather S Siddiqui MD
2049 Evans St
Oshkosh WI 54901

VS/TS
Dennis D Woodhall MD
411 Lincoln St
Neenah WI 54956

County society transfers

DANE

(from Waukesha)
Susan M Torhorst MD
5900 Monona Dr, #200
Madison WI 53716

EAU CLAIRE/DUNN/PEPIN

(from Chippewa)
Steven L Rosas MD
2211 Stout Rd
Menomonie WI 54751

WAUKESHA

(from Milwaukee)
Lynn K Di Ulio MD
210 Regency Ct
Waukesha WI 53186

Lawrence L Foster MD
13225 W Bluemound Rd
Brookfield WI 53005

Diane M Goetz MD
2717 N Grandview Blvd
Waukesha WI 53188

Michael Phillips MD
8140 W Wisconsin Ave
Wauwatosa WI 53213

Richard M Schaefer MD
14405 Ridgemoor Dr
Elm Grove WI 53122

WINNEBAGO

(from Milwaukee)
Jeanna L Owens MD
400 Ceape Ave
Oshkosh WI 54901■

Alcoholics Anonymous

The State Medical Society's Committee on Alcohol and Other Drug Abuse recommends that physicians be aware of the Central Offices of Alcoholics Anonymous as a support group in the care of their patients.

Green Bay	Madison	Superior-Duluth
414-437-9971	608-222-8989	218-728-5572
Kenosha	Milwaukee	La Crosse
414-654-8246	414-272-3081	608-784-7560

It should be emphasized, however, that patients should make the call to the Central Office because Alcoholics Anonymous cannot be of assistance unless the patient wants help.

Each of these Central Offices has a list of recovering alcoholics who will call the patient and offer help. If there is no Central Office listed in an area, patients should check the local phone book under Alcoholics Anonymous. Often a local phone number will be listed where there is no Central Office.■

PHYSICIANS EXCHANGE

Several Emergency Physicians, Board-certified/eligible, are needed to staff Level II Emergency Department with annual volume of 30,000 plus, July 1, 1988. Residents rotate through department making excellent teaching opportunity. Compensation package exceeds 120,000/yr. Flexible scheduling, 36 hr/wk, 1656 hr/yr. Partnership available in one year. Contact Sunil K Ahuja, MD, FACEP, Medical Director, Emergency Services at Sinai-Samaritan Medical Center, 2000 W Kilbourn Ave, Milwaukee, WI 53233; ph 414/937-5989. p3-4/88

Family Practitioner to associate with a highly successful two physician (one physician near retirement) rural family health center with an excellent support staff and unlimited potential. Complete fee-for-service practice with excellent hospitals and specialty support only minutes away. Guaranteed salary, incentives and benefits tailored to fit your needs. Located 15 minutes from a major metropolitan area and 30 minutes from the joys of Door County. Interested physicians please contact J C Majeski, Clinic Mgr, Luxemburg Medical Clinic, PO Box C, Luxenburg, WI 54217; ph 414/845-2351. p3-5/88

Rheumatologist—the Racine Medical Clinic a 34-physician multispecialty group conveniently located between Chicago and Milwaukee. Well equipped clinic offering salary guarantee with incentive bonus; excellent fringe benefits and early ownership. Please send curriculum vitae to: R D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 11tfn/87

BC/BE General Internist to join 26-MD multispecialty group with four internists, one nephrologist and one gastroenterologist. Top salary first year, full incentive thereafter. Central Wisconsin university town with drawing area of 80,000. Send CV to Dr John Gauder, Rice Clinic, SC, 2501 Main St, Stevens Point, WI 54481, or call collect 715/344-4120. 12tfn/87

RATES: 50¢ per word, with a minimum charge of $20.00 per ad. BOXED AD RATES: $25.00 per column inch. *All ads must be prepaid.*

DEADLINE: Copy must be received by the 15th of the month preceding month of issue; *eg,* copy for the August issue is due July 15. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 1-800-362-9080.

Family Practitioner needed for ambulatory medicine/urgent care clinic. Large, modern facility in rapidly growing Milwaukee suburb. ER experience and interest in patient education helpful. Enjoy autonomy, flexible scheduling and competitive financial package without call requirements. Send CV to Julie Larsen, MD, 17260 W Bluemound, Brookfield WI 53005. p4/88

Internal Medicine. Board-certified or eligible to join five general internists in a multispecialty group in northeastern Wisconsin. Office is next to two hospitals. Partnership is available after one year. Send CV to Dept 613 in care of the Journal. p4-9/88

Family Practice physician. Challenging opportunity, Northeastern Wis; salary plus benefits, rural community health centers, hospital practice not required, tourist area, national forest. Contact Northern Health Centers, PO Box 179, Lakewood, WI 54138; ph 715-276-6321. p4-6/88

Family practice. Thirty-four physician multispecialty group conveniently located between Chicago and Milwaukee. Well-equipped clinic offering salary guarantee with incentive bonus; excellent fringe benefits and early ownership. Please send current curriculum vitae to Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 4tfn/88

The Wausau Medical Center is seeking BE/BC individuals in the following specialties: Cardiology, Dermatology, Family Practice, Infectious Disease, Obstetrics/Gynecology, Pediatrics and Rheumatology. Modern clinic facility located across the street from modern 300-bed hospital. Full partnership in three years. Easy access to lakes, woods and mountains. Write including CV to D K Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, WI 54401. p4tfn/88

Physician. Seeking primary care physician to work in established physician's office in West Allis. Flexible hours, possible long term affiliation. Hospital and office practice. Guaranteed compensation plus incentive option. Please contact Barton-Collins, Ltd, Consultants, 9401 West Beloit Rd, #313, Milwaukee, WI 53227; ph 414-541-6099. 4/88

Full-time position of eight 24-hour shifts available in NE Wisconsin community hospital with annual ED volume of 10,000. Pleasant town located on Lake Michigan just 70 miles north of Milwaukee. $95,000 plus paid malpractice insurance. Please respond with CV to Dan Brachman, Vice President, Marketing, 2300 Western Ave, Manitowoc, WI 54220. p4-5/88

Wisconsin. Forty miles from Madison. Fifty-five physician multispecialty group seeks second psychiatrist. An increased patient volume and addition of a drug and alcohol inpatient unit necessitates addition of one to two additional psychiatrists. The current psychiatrist is BC in adult and BE in child and geriatric. Contact Jean Ecos, 250 Regency Court, Waukesha, WI 53186; ph 1-800-338-7107, or 1-414-785-6500 (collect). 4/88

Pediatrician (BC/BE) to join five dynamic BC pediatricians in a 38-physician multispecialty group. Newborn stabilization skills required. Teaching environment with residents on service six out of 12 months. Cultural and outdoor recreational opportunities excellent. Send CV to Kurt Heyrman, MD, 401 North Oneida St, Appleton, WI 54911. 4-6/88

Wisconsin—Milwaukee, BC/BE pediatrician. Dual role of primary care pediatrician and consulting pediatrician. Must be well-rounded and personable. Teaching opportunities. Active at Children's Hospital and community hospitals. Contact Dept 612 in care of the Journal. p4/88

General Surgeon. Board-certified general surgeon needed to join expanding 85-physician multispecialty medical center in Los Angeles and Orange counties. An exceptional base salary and incentive plan. Benefits include malpractice insurance, group health and life insurance. Please send CV to Dept 604 in care of the Journal. 3-4/88

Physicians needed full- or part-time to perform light physicals. Milwaukee area. Professional liability provided. Phone 414/344-2100, Ms Jenkins. 10tfn/84

OB/GYN, Board-certified or eligible, to join highly progressive, rapidly growing practice. Normal and high risk obstetrics emphasized along with highest levels of infertility care (microsurgery, GIFT, IVF, Laparoscopic Laser Surgery), as well as extensive gynecology and surgery practice. Easy lake country or Milwaukee suburban living. Salary and guarantees to meet your needs with opportunity for partnership in one year. Available July 1988, or earlier. Contact Matt Meyer, MD, Women's Health Care, SC, Milwaukee Regional Fertility Center, 426 W Main St, Waukesha, WI 53186; ph 414/549-1333. 3-5/88

Urologist physician Board-certified/Board-eligible to join 23-physician multispecialty group in Winona, Minnesota. Total draw area of 40,000 population. Competitive salary offered. Interested physicians please contact J B Knuesel, Administrator, Winona Clinic, Ltd, 420 East Sarnia, Winona, MN 55987. 2-4/88

PHYSICIANS EXCHANGE

continued

Primary Care Physicians—Family Practice, General Practice, or ER experience desirable. To staff clinics for industrial, walk-in, after hours, and satellite medicine. Excellent opportunity—guaranteed salary, profit-sharing, great fringes. Send CV to Administrator, Manitowoc Clinic, PO Box 3008, Manitowoc, WI 54220. p7-12/87; 1-5/88

Internal Medicine physician Board-certified/Board-eligible to join 23-physician multispecialty group in Winona, Minnesota, with existing nine-physician Internal Medicine Department. Total draw of 40,000 population Competitive salary offered. Interested physicians please contact J B Knuesel, Administrator, Winona Clinic, Ltd, 420 East Sarnia, Winona, MN 55987. 2-4/88

Wisconsin. OB/GYN (BC/BE) needed to join dynamic HMO-based multispecialty group practice. University town of 55,000 near Minneapolis. Community and recreation outstanding. Competitive salary and fringes. We take pride in our patient care. Contact: Robert A Braastad, MD, Group Health Cooperative, 1030 Regis Court, Eau Claire, WI 54701; ph 715/836-8552. p12/87;1-4/88

Pediatrician to join existing two-person practice at the 23-physician multispecialty Winona Clinic, Ltd, in Winona, Minnesota. Located in the beautiful Mississippi River Valley of southeast Minnesota. The community with a 40,000 population trade area is the host of three colleges and a diverse industrial base. Send CV to J B Knuesel, Administrator, Winona Clinic, Ltd, 420 East Sarnia, Winona, MN 55987. 2-4/88

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West Bend, Wisconsin, General Clinic, a 20-physician multispecialty group is seeking additional B/C, B/E physicians in **Family Practice, Pediatrics, OB/GYN, Internal Medicine, Urology, Dermatology,** and **ENT.** First-year salary and benefits guaranteed. Corporate association after one year. Located in a family-oriented, economically strong small city surrounded by four-season recreational and scenic Kettle Moraine area 30 miles north of metropolitan Milwaukee. Contact Hans W Schmelzling, Administrator, 279 S 17th Ave, West Bend, WI 53095; ph 414/338-1123. 7tfn/87

Excellent opportunity for a Board certified or eligible **ob/gyn** to practice in conjunction with a 4-member OB/GYN Department of a 28-member multispecialty group. The group is located in southeastern Wisconsin, in a city of 100,000 between two major metropolitan areas. If interested, please send CV to: William H Olson, Kurten Medical Group, 2405 Northwestern Ave, Racine, WI 53404. All inquiries will be kept confidential. 5tfn/86; c1tfn/88

Twenty-nine physician multispecialty clinic located in desirable East Central Wisconsin location is seeking Board-certified or Board-qualified orthopedic surgeon to round out its services. Lab, x-ray, excellent hospital. Liberal guarantee and benefits. If interested contact D F Sweet, MD, Fond du Lac Clinic, SC, 80 Sheboygan St, Fond du Lac, WI 54935. 9tfn/87

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(608) 231-3030 4-6/88

Pediatrics—Marshfield Clinic, a 250-physician multispecialty private group practice, is seeking a Board-certified or eligible general pediatrician to join its expanding regional center in Chippewa Falls. Chippewa Falls is a community of 15,000 people located in beautiful west central Wisconsin with a wide range of recreational, educational, and cultural opportunities easily accessible. The clinic is adjacent to a 110-bed JCAH accredited hospital. Competitive salary and fringe benefit package. Send curriculum vitae and references to Mr David Draves, Director, Regional Development, Marshfield Clinic, 1000 North Oak Ave, Marshfield, WI 54449 or you may call collect at 715/387-5376. 4/88

Family Practice—Madison, Wisconsin. Eleven-year-old staff model HMO has a family practice position available. We offer a very attractive practice setting with reasonable scheduling, excellent salary and benefits. Contact: John Hansen, MD, Medical Director, Group Health Cooperative, One South Park, Madison, WI 53715; ph 608/257-9700. 4-6/88

BC/BE General Surgeon. Outstanding opportunity for general surgeon to associate with two active internists in a friendly rural community in Northeastern Wisconsin near Green Bay. New clinic attached to a 55-bed community hospital. Excellent long-term growth potential. Send CV to Artwich Clinic, Ltd, 815 South Main St, Oconto Falls, Wis 54154. p2-4/88

Family Practice Clinic in central Wisconsin seeking family practitioner for a five-man group with two locations. Excellent compensation and fringe benefits. Send CV to John Thompson, MD, at 315 First St, Nekoosa, WI 54457 or call collect at 715/886-3175. p4-5/88

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UW Office of Rural Health
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Madison, WI 53705
608/263-7933
7-12/87; 1-6/88

Beloit Clinic, SC, an expanding multispecialty group in southern Wisconsin college town is seeking a pulmonologist, a gastroenterologist, and a general surgeon with vascular capabilities for its main facility, as well as a family practitioner for a satellite location. Guaranteed salary with incentive plus excellent fringe benefits. Send CV to J F Ruethling, Administrator, 1905 Huebbe Parkway, Beloit, WI 53511; ph 608/364-2200. 4-6/88

PHYSICIANS EXCHANGE

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BC/BE Internist. Outstanding opportunity for general internist to join two active internists in a busy practice of internal medicine in a friendly rural community in Northeastern Wisconsin near Green Bay. New clinic attached to a 55-bed community hospital with new ICU/CCU. Excellent long-term growth potential. Send CV to Artwich Clinic, Ltd, 815 South Main St, Oconto Falls, Wis 54154. p2-4/88

Family Practitioner. Clinic seeking a well-rounded physician to practice at a growing established satellite clinic 30 miles north of main clinic. Clinic located in a friendly rural community with year-round outdoor activities. Send CV to Artwich Clinic, Ltd, 815 South Main, Oconto Falls, Wis 54154. p2-4/88

Orthopedic Surgeon. Board-certified/Board-eligible to join a 23-physician multispecialty group in Winona, Minnesota. Total patient population draw area of 40,000. Interested physicians please contact J B Knuesel, Administrator, Winona Clinic, Ltd, 420 East Sarnia, Winona, MN 55987. 2-4/88

Family Practice, Pediatrics, and Internal Medicine—Park Crest Medical Clinic in suburban Milwaukee has immediate openings in these three specialties. For more information, please contact Sherry VanErt, 2665 S Moorland Rd, New Berlin WI 53151: ph 414/786-1199. p4-7/88

Eagle River—Great opportunity for two BC/BE family practice physicians to join well-established practice. Guaranteed annual income and future partnership available. For more information, send resume to Judy Harris, Recruiter, UW Office of Rural Health, 810 University Bay Dr, Madison, WI 53705 or call collect 608/263-7933. 1tfn/88

Internal Medicine. Board-certified or eligible to join four general internists in a multispecialty group in northeastern Wisconsin. Office is next to two hospitals. Partnership is available after one year. Send CV to Dept 596 in care of the Journal. p8-12/87· 1/88; 2-4/88

Emergency Medicine, Otolaryngologist, Urologist, and Obstetrician/Gynecologist to join multispecialty group practice in Woodruff, WI. Guaranteed annual income and excellent fringe benefit program. Send CV to R J Sloan, MD, Lakeland Medical Associates, Ltd, PO Box 549, Woodruff, WI 54568. 4tfn/88

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MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

WISCONSIN

APRIL 26, 1988: *Wisconsin Academy of Ophthalmology,* held in conjunction with the Milwaukee Opthalmic Society meeting, University Club, Milwaukee. Info: 414/259-1930 (Arleen). g1-3/88

APRIL 28–30, 1988: State Medical Society of Wisconsin Annual Meeting, Milwaukee.

MAY 6, 1988: *Wisconsin Orthopaedic Society,* American Club, Kohler g4/88

MAY 13–14, 1988: *Moving Over or Moving Out: The Older Health Care Professional Deals With the Present and the Future.* Seminar for the older health care professional who, in dealing with the changes in the system, is considering career options *vs* adjustment will be presented on Friday evening, May 13, and Saturday, May 14 at the Olympia Village Conference Center, Oconomowoc. Topics include identifying the problem and its effects on the individual and relationships, ethical dilemmas, and decision making. This seminar is being co-sponsored by Bellin Hospital, Green Bay, and the Howard Young Medical Center, Woodruff, in cooperation with the Medical College of Wisconsin, Milwaukee. Info: call 414/433-7815. p3-4/88

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 50¢ per word, with a minimum charge of $20.00 per listing. *All listings must be prepaid*

BOXED LISTINGS: $25.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 15th of the month preceding the month of publication; eg, copy for the August issue is due by July 15. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll free in Wisconsin, 1-800-362-9080

FOR LISTING of other meetings see the January 1, 1988 issue of the *Journal of the American Medical Association:* Continuing Education Opportunities for Physicians for period March 1988 through August 1988.

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

continued

JUNE 2, 1988: *Gastroenterology for the Practicing Physician* at Red Carpet Hotel/Airport, 4747 South Howell Ave, Milwaukee. Sponsored by The Center for Digestive Disorders at Trinity Memorial Hospital, and Merck, Sharp & Dohme Pharmaceuticals. 9:30 am–3:30 pm. Lunch provided. No charge. Course director, Joseph E Geenen, MD. Info: James G Streed, Trinity Memorial Hospital, 5900 South Lake Dr, Cudahy, WI 53110; ph 414/769-4050. g2tfn/88*

JUNE 3–4, 1988: Wisconsin Radiological Society and the Milwaukee Roentgen Ray Society, American Club, Kohler. g11-12/87;1-5/88

JUNE 16–19, 1988: Wisconsin Academy of Family Physicians, Holiday Inn, Stevens Point. g10tfn/87

JULY 21–23, 1988: *Wisconsin Society of Obstetrics and Gynecology,* Landmark Resort, Egg Harbor. g1-6/88

JULY 29–31, 1988: Wisconsin Dermatological American Club, Kohler. 12tfn/87

AUGUST 3–8, 1988: *"International Doctors In Alcoholics Anonymous,* Stouffer Hotel, Baltimore, MD. Info: Information Secretary, IDAA, 1950 Volney Rd, Youngstown, OH 44511; ph 216/782-6216. g1-7/88

SEPT 9–11, 1988: Wisconsin Society of Anesthesiologists, Convention Center/Embassy Suites, Green Bay. g10tfn/87

OCTOBER 1, 1988: *Wisconsin Society of Radiation Oncologists,* Concourse Hotel, Madison. 4tfn/88

OCTOBER 20–21, 1988: Wisconsin Chapter, American College of Emergency Physicians, The Abbey, Lake Geneva. 2tfn/88

NOVEMBER 4, 1988: *Wisconsin Orthopaedic Society,* Olympia Resort, Oconomowoc. 4tfn/88

NOVEMBER 5, 1988: *Wisconsin Allergy Society,* Edgewater Hotel, Madison. 4tfn/88

AMA

JUNE 26–30, 1988: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 4–7, 1988: Interim House of Delegates, Dallas, TX.

JUNE 18–22, 1989: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 3–6, 1989: Interim House of Delegates, Honolulu, HI.

JUNE 24–28, 1990: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 2–5, 1990: Interim House of Delegates, Orlando, FL.■

Wisconsin Specialty Society Meetings 1988

- Wisconsin Chapter-American Academy of Pediatrics Annual Meeting, American Club, Kohler, April 22, 1988.
- Wisconsin Radiological Society and the Milwaukee Roentgen Ray Society, June 3–4, 1988, American Club, Kohler.
- Wisconsin Academy of Family Physicians, June 16–19, 1988, Holiday Inn, Stevens Point.
- Wisconsin Society of Obstetrics and Gynecology, July 21–23, 1988, Landmark Resort, Egg Harbor.
- Wisconsin Society of Anesthesiologists, Sept 9–11, 1988, Convention Center/Embassy Suites, Green Bay.
- Wisconsin Society of Internal Medicine, Sept 15–17, 1988, Milwaukee Marriott.
- Wisconsin Radiological Society, Sept 30–Oct 1, 1988, Concourse Hotel, Madison.

* * *

Specialty Society Meetings to be held in conjunction with SMS Annual Meeting, April 28–30, 1988, Milwaukee

- Wisconsin Allergy Society
- Wisconsin Society of Anesthesiologists
- Wisconsin Chapter, American College of Emergency Physicians.
- Wisconsin Academy of Family Physicians
- Wisconsin Society of Pathologists
- Wisconsin Society of Physical Medicine and Rehabilitation
- Wisconsin Society of Radiation Oncologists

State Medical Society of Wisconsin

Dates and locations of ANNUAL MEETINGS 1988–1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel, unless otherwise indicated.

1988—April 28–30
1989—April 13–15
1990—April 26–28: ***Green Bay***
Convention Center, Embassy Suites
1991—April 18–20
1992—April 23–25

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

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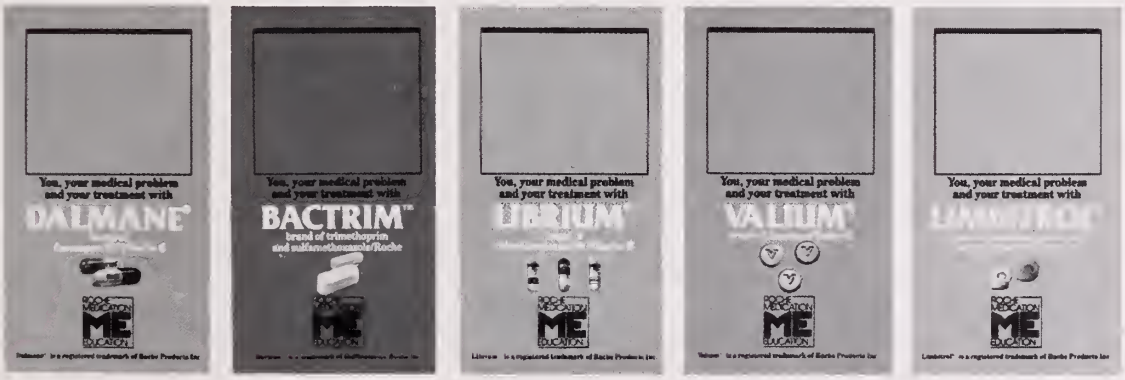

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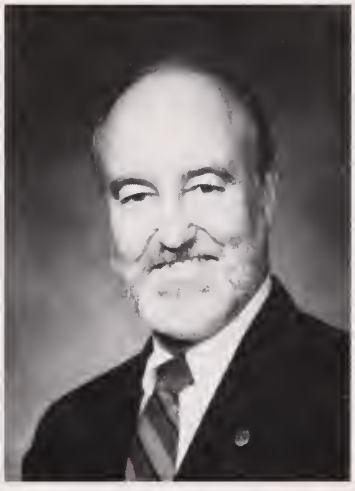

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The threat of radon in Wisconsin . . . Radon levels in many parts of Wisconsin are higher than previously suspected, and the estimated number of radon-related deaths in the US is between 5,000 and 20,000 per year (see page 17).

SMS has a new president . . . JD Kabler, MD, was elected president of the State Medical Society of Wisconsin at the Annual Meeting in April (see page 5).

Moonlighting . . . A survey of elderly Wisconsin physicians uncovers a secretive but time-honored medical tradition (see page 15).

Physicians, their families, and stress . . . The Loss Prevention Corner takes a look at the more personal costs of professional liability suits (see page 33).

PartnerCare covers the state . . . Initial physician sign-up in the voluntary Medicare assignment program is complete (see page 43).

MAY 1988

WISCONSIN MEDICAL JOURNAL

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WISCONSIN MEDICAL JOURNAL (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the editorial board, subject to policy direction of the Society's Board of Directors. The managing editor is responsible for overseeing the production, business operation, and contents of the Journal. The editorial director is responsible for editorials. Unsigned editorials express views consistent with the policies of the State Medical Society of Wisconsin. Signed editorials express personal views of the author for which the Society takes no responsibility. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus," "Hospital Literature Index," and "Cambridge Scientific Abstracts."

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THE STATE MEDICAL SOCIETY OF WISCONSIN, created by the Territorial Legislature in 1841, represents nearly 7000 member physicians in Wisconsin, comprising 55 county medical societies and 28 medical specialty sections. The purpose of the Society is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society include continuing medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, services for physicians, operation of a Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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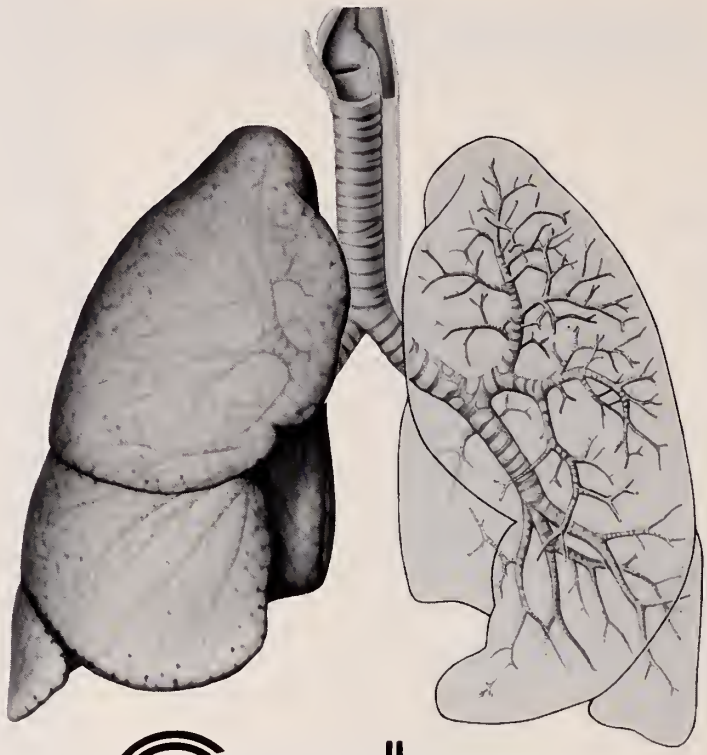

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Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β-hemolytic streptococci).

Contraindication:
Known allergy to cephalosporins.

Warnings:
CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)
Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.

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- Slight elevations in hepatic enzymes.
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Introducing President JD Kabler, MD

JD KABLER, professor of medicine and director of the University Health Service of the University of Wisconsin–Madison, was elected president of the State Medical Society of Wisconsin during its annual meeting in April 1988.

Dr Kabler, a certified specialist in internal medicine with a special interest in the treatment of headache, is a consultant to the Veteran's Administration Hospital and an active member of the medical staff of University Hospitals in Madison. He was president of the University Hospitals medical staff from 1979 to 1982.

He earned a baccalaureate, with election to Phi Beta Kappa, in 1947 and a medical degree, with election to Alpha Omega Alpha, in 1950 from the University of Kansas. Dr Kabler trained as an intern, resident and fellow at University Hospitals in Madison and was elected to Sigma Xi.

A member of the State Medical Society of Wisconsin since 1951, Dr Kabler has served as chairman of both the Society's Commission on Governmental Affairs and Joint Practice Committee. He has been a member of the SMS Board of Directors in 1979.

Dr Kabler has served as president of the Dane County Medical Society, the Madison Academy of Internal Medicine, and the Wisconsin College Health Association. He is a Fellow of the American College of Physicians and a member of the American Psychosomatic Society, the American Association for the Study of Headache, the Society of Military Surgeons and the Society of Medical Consultants to the Armed Forces. He served in the Wisconsin Army National Guard from 1956 to 1974, was chief surgeon from 1967 to 1974, and was decorated with the Legion of Merit.

Dr and Mrs Kabler are parents of five children, and grandparents of three.■

Assessment shock

NEWS OF THE 31.7% increase in the Patients Compensation Fund assessment for physicians came as a bit of a shock since the mandatory increase in base liability coverage to $400,000/$1,000,000 on July 1, 1988, could have been expected to decrease the pressure on the fund. Actually, the rise in combined costs will be greater this year than in the past several and, coupled with the continued federal constraints on fee schedules, income cannot keep pace with overhead.

In the past, one way to keep income rising at the same rate as overhead when Medicare fees were fixed, was to set fees higher in those areas where there was no freeze. But as the number of patients who belong to fixed-schedule plans increases, that option dries up too.

Simple rules of economics will prevail: Doctors on the margin of profitability will retire younger than they otherwise would have, and beginners will shun private solo practice and be forced into situations where their overhead is paid by a group. The obituary of the solo practitioner was written in these columns several years ago, and need not be rewritten, but it is sad that modern practice will soon be without the practitioner who gave it so much of its class and dignity.

I do have to wonder why the Fund assessment had to be so large at a time when primary coverage has virtually doubled, though. Are there that many awards over $400,000? If there are, then those same simple rules of economics must tell us that unless some sort of upper limit on awards is set soon, certain specialties are going to be in short supply in Wisconsin.

—Wayne J. Boulanger, MD
Milwaukee

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A moral equivalent to medical lawsuits

CARLETON B. CHAPMAN, in his book *Physicians, Ethics and Law,* reviews the history of medical ethics and its relationship to law.[1] In the first pages of his book, he makes this strong statement: "There is little evidence of the patient-centered ethic in the codes and pronouncements of medical bodies from the days of imperial Rome to our own." After giving a detailed history of medical ethics, Chapman advises the medical profession to do two things. "First, to clarify its basic position by placing the patient—not the profession—at the center of its considerations. Second, to make a firm unfettered appraisal of the profession's ancient tradition of authority."

Most physicians will agree that medical liability is one of the prime problems for their profession and their patients. However, perhaps we physicians have let it become a problem since we have been slow to provide an insurance program that would protect our patients in the event of a medical maloccurrence. We have been accused of "a conspiracy of silence" and of sometimes covering up our failures. As a result, our patients have had no recourse but to turn to the civil court system for compensation and redress.

Will the medical liability problem ever go away? Chapman says no. "While professional negligence may be reducible to some very low incidence, it can never be abolished altogether; neither can the so-called statistical accident."

What can we as a medical society do? Obviously we should continue to study the problem, but perhaps we already have an answer. This could be a patients' insurance compensation plan modeled after the workers' insurance compensation plans that are present in every state in the nation. In 1911, the Wisconsin State Legislature enacted the first workers' insurance compensation law. This law was one of many advocated by Robert LaFollette and his associates, the Progressives. The Progressives of Wisconsin led the nation in providing laws which stressed social justice for children, women, teachers, and industrial workers.

A patients' compensation plan modeled after workers' insurance compensation plan would ethically satisfy the recommendations of Chapman. It would be patient-centered just as the workers' insurance compensation plan is worker-centered. Also a patient insurance compensation plan would have physicians give up authority to the patient just as the employer gives up authority to the employee in the workers' insurance compensation plans.

In 1911 when the Progressives in Wisconsin were seeking social justice by enacting social legislation, William James had written an article with the provocative title, "The moral equivalent of war."[2] James described moral methods that could counteract the adversarial tendencies of men that lead to war. The Progressives sought social justice and William James emphasized morality. Any patient insurance compensation plan must include foundational considerations of both social justice and morality. The plan will be successful if it can be made as nonadversarial as possible.

A patients' compensation insurance plan modeled after the Wisconsin Worker's Compensation Plan should be carefully studied as a possible solution to the medical liability problem. It can be patient-centered and can transfer authority to the patient. This plan could become a moral equivalent to medical lawsuits following careful deliberation by persons in the medicine, law and government.

1. Chapman, CB: Physicians, Law and Ethics. New York and London; New York University Press, 1984.
2. James, W: The Annals of America, Vol 13. Chicago; Encyclopaedia Brittanica. 1968 pp. 254-260.

—*John O. Simenstad MD, PhD*
SMS Committee on Medicine, Religion and Ethics
Osceola

Editor's note: A patient's compensation insurance plan would presumably compensate for all unhappy medical outcomes. In our society I believe this would be translated to mean payment to everyone who came out of an illness in worse shape than before the illness. The system would soon be swamped logistically and financially, and true malpractice would be inadequately addressed.—*WJB*

Stemming the tide of government interference

THIS IS A STORY that involves the Freedom of Information Act. The Freedom of Information Act was passed in 1966, revised in 1974, and designed to make it easier for the public to extract information from the government. It has allowed clergymen to discover the contents of files compiled on them by the FBI, conservationists to keep an eye on James ("Raider Of The Last Park") Watt's shenanigans when he was secretary of the interior—and it has recently been invoked by our local hospital in an attempt to get WPS and Medicare to release information about regulations pertaining to reimbursement for professional services.

The situation involved the interpretation of WPS-Medicare regulations concerning billing by two physicians for initial examinations of a single hospitalized patient. The answer to the question was simple, and should have been simple to obtain. This was not the case, however. The request was stonewalled by WPS, which actually *suggested* that our hospital invoke the Freedom of Information Act. When our hospital did, WPS advised that the request for information had been lateraled to the Health Care Financing Administration. An answer was finally obtained by our hospital's consulting the State Medical Society.

If this whole thing strikes you as asinine, it should. I think this, as

much as anything, illustrates the attitude the government is taking in dealing with physicians and hospitals. At the very least, it is a heavy-handed attempt by the government to cover up for an inexcusable lack of clarity in its regulations. When taken a step further, however, one can envision Medicare having these regulations in place and not telling physicians and hospitals what they are, and then pointing to "flagrant violations" of the regulations a few years from now, leaving it to physicians and hospitals to try to prove that they had not been properly informed about the regulations in the first place. In the mind of the public, the charge always carries more weight than the countercharge. Such a tactic would open the way for imposition of even stricter government control over medicine in the future.

Our hospital is considering notifying our legislators of this incident, underscoring its good faith attempt to comply with government regulations and contrasting this to the government's conduct in the matter.

I would encourage all hospitals and physicians who find themselves in similar circumstances to do the same. It may do no good at all, but the *only* hope that we as physicians have of stemming the tide of government interference in medicine is to point out these incidents as they occur, clearly, honestly, and loudly. The well-documented complaints of individual physicians or hospitals will have more effect on the conscience of a legislator than the sleekest overtures of a political action committee. Looking at the worst possible outcome, in which medical care in America comes crashing down around our ears in another ten years or so, I would rather be in a position of saying to a disillusioned public, "I tried to tell you," than to be saying, "I should have told you."

If this incident is typical, it is little wonder that physicians might be feeling paranoid about their financial partnership with Uncle Sam and his minions. The question we should be asking ourselves is not whether we are paranoid, but whether we are paranoid *enough*. After all, just because you are paranoid doesn't mean they aren't really out to get you.

—Jeffrey H. Lamont, MD, FAAP
Wausau

Active euthanasia

THE BATTLE IS on. The battle to which I refer concerns the soul of the medical profession and its vital core, the ethical mandate to do no harm. In the celebrated case of Debbie, the young lady dying of metastatic ovarian carcinoma, a young, tired resident dispatches her

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with an overdose of morphine, a so-called mercy killing.

The editor of the *Journal of the American Medical Association,* Dr George Lundberg, chose this anonymous piece to initiate the debate on active euthanasia in the United States. He recently won his case in court when a subpoena was quashed which sought the identity of the young physician. The published piece has generated, as the editor expected, a considerable reaction from *JAMA* readers and the public. Dr Lundberg has achieved what he was after, viz, interest in the active euthanasia movement and the need for public discussion.

In a recent editorial in *JAMA* (April 8, 1988), Dr Lundberg spells out, in unequivocal fashion, the background of his interest in this area and the reasons for publication of "It's Over, Debbie." He expounds at length on the public interest and the profession's interest in active euthanasia. He suggests a public debate, a modification of our attitude as a profession toward active euthanasia. While all this may sound rather academic and reasonable, it seems rather naive of the editor to think that discussions on the dangers of active euthanasia have not already taken place. Euthanasia and assisted suicide have been hotly debated in medical and ethical journals for many years. To use the *JAMA* to lead this debate is neither wise nor prudent and is totally offensive to the medical profession, which is responsible for its existence and for maintaining its medical ethic. To use the *JAMA* to promote this debate in view of the policy decision of the AMA House of Delegates and Judicial Council against active euthanasia, is an egregious and presumptuous decision by Dr Lundberg. The role of the *JAMA* is to promote, defend and elucidate the action of the AMA in its stand against active euthanasia. To use the *JAMA* to spread the insidious, corrupting message of the Hemlock Society and its followers is a misuse of the most visible public organ of the AMA. The Hemlock Society and others who favor active euthanasia already have vehicles in the media spreading their message in the most beguiling fashion. We physicians are in no need of having similar messages printed in our journal to subvert and corrupt our ethic.

This is not the time for neutral discussion in which physicians are encouraged to forsake their Hippocratic ideals. We have too many examples of this in the not-so-distant past of Germany, in which we see what happens when a medical profession loses its soul. The resulting Holocaust is too vivid in our memories to forget, and the stain of this abandonment of the Hippocratic tradition still remains for all the world to ponder.

In an accompanying article in the April 8 issue of *JAMA*, Leon Kass, Edmund Pellegrino, Mark Siegler and Willard Gaylin issue a clarion call to us all: "Now is the time for the medical profession to rally in defense of fundamental moral principles, to repudiate any and all acts of direct and intentional killing by physicians and their agents. We call on the profession and its leadership to obtain the best advice, regarding both theory and practice, about how to defend the profession's moral center and to resist growing pressures from without and within. We call on fellow physicians to say we will not deliberately kill. We must say also to each of our fellow physicians that we will not tolerate killing of patients and that we shall take disciplinary action against physicians who kill. And we must say to the broader community that if it insists on tolerating or legalizing active euthanasia, it will have to find non-physicians to do its killing."

In regard to the editorial policy of the *JAMA* and its decision to publish the Debbie piece, and its subsequent legal difficulties, it is encumbent upon the Board of Trustees and its Judicial Council to thoroughly investigate this whole area. As Pellegrino et al state, "Justice requires nothing less." In regard to the euthanasia debate, the editorial policy should be to formally reject anything submitted which speaks in favor of active euthanasia. If the editor cannot live with this editorial policy, he can be relieved of his job. This is not the time for neutral debate on an issue central to our medical ethic. The Board of Trustees must run the association and not have the staff subverting its public policy against active euthanasia.

—John P. Mullooly, MD
Milwaukee■

LETTERS

Medicare assignment

Editor's note: The following letter from Norman F. Deffner, MD, president of the Marathon County Medical Society, is an excerpt from his response to a letter from Shirley Doane, president, and Thomas L. Frazier, executive director, of the Coalition of Wisconsin Aging Groups.

Doane and Frazier outlined three basic reasons for asking physicians to voluntarily agree to participate in the Federal "Participating Physician" Medicare program for 1988:

Income. Older persons are not wealthy—their median annual income is $12,004.

Shoebox syndrome. Older persons are overwhelmed with the paperwork associated with Medicare.

Voluntary program. Because participation is voluntary, there are some areas of the state where participation is low, and older persons are deferring proper health care because they feel they cannot afford it.

DEAR MS DOANE and MR FRAZIER:

. . . a recent survey of our local internists, general practitioners and specialists show that they are currently receiving $10.25 to $13.60 from Medicare per office visit. They are allowed to bill the patient an additional 20%—which costs as much to bill as it collects. In many cases, the fees allowed by Medicare do not cover the physicians' expenses of $50

to $80 per hour—excluding their own salaries! No one can realize a constant loss and stay in any business. If we saw only a few Medicare patients, and if we could collect our regular fees (which are usually nearly double what Medicare allows), we could still survive.

The problem facing us is that an increasing percentage of our patients are either on Medicare assistance, HMO, PPO, IPA or prepaid Medical Plan, all of which have racheted down their reimbursement rates—leaving physicians less and less net to be taken as salary. I'm sure you're aware that since 1984, we've received essentially no increase in payment in a system that was already two years behind in equity payments.

Another problem is that the elderly frequently have more than one problem and the time and effort required to evaluate these problems—often lengthened by patients' diminished abilities to hear, see, and comprehend—is frequently twice that required for a younger patient. Overhead, therefore, is markedly increased. Yet Medicare does not recognize the increased level of cognitive services, and reimburses at a low rate.

. . . If the trend continues, you'll soon have bargain-rate physicians, but you'll not receive the world's best medical care. Can you help us by presenting these facts to our congressmen, so that these rates can be increased? You'd then see an increase in participation, as most of us would like to participate but can't afford to under the present system.

We are sympathetic to the Shoebox syndrome, although physicians are not the cause of the confusion. . . I have asked, and will again ask, that all our member physicians who are not already doing so, give strong consideration to helping the elderly with their insurance forms.

Here, again, you would be of immense help if you would write our representatives and get Medicare regulations changed so that the physician would always get an EOB from Medicare, thus allowing our staffs to verify for the patient the correct payment and to bill the secondary carrier when available. We currently cannot get this necessary information unless we accept assignment or get it from the patients long after they've left the office—which is another expense.

I think most physicians would volunteer if you were successful in changing the rate of reimbursement for most basic cognitive services.

Surely you relish the freedom we still have in the United States. Many have fought and died for this freedom through the years. Is this still a land of the free when what we can do, how it will be done, and what we will be paid for it is dictated by one central government authority? Are physicians second-class citizens in the world's greatest democracy? Is any system really voluntary when, ultimately, the alternative is the inability to perform your profession at all—under any circumstances?

One further point: Our society's physicians have agreed to accept assignment under the PartnerCare program for those patients who are near the poverty level. I should add that, even though many of us are not participating physicians, we routinely take assignment on any and all hardship cases.

—Norman F. Deffner, MD
President
Marathon County Medical Society

Home health care increases

In the 1986 Wisconsin Annual Survey of Home Health Agencies, home health employees reported almost 2 million home health visits to 61,000 patients. This represents an increase of nearly 500,000 visits since 1983.

Although the average number of visits per patient remained relatively constant (32), the number of patients visited increased by 38% between 1983 and 1986.

The greatest percentage increase in home health use occurred in the 55 to 64 age group—133%.—*Wisconsin Division of Health*■

Medicare injection information

TO THE EDITOR: After spending approximately 45 minutes on a phone call to the Medicare office requesting information on what injection drugs are payable by Medicare, we were informed that any inquiries must be of a specific nature in writing. Any further information we requested could be found by us in our public library, but they could not furnish us with a conclusive list that we requested.

I feel that physicians may want to tell their patients at the time of service that all injectable medications may not be covered by Medicare and ask them to sign a release stating that they will be responsible for the charge should Medicare deny payment. This action may eliminate a $2,000 fine per non-covered service.

—Nicholas R. Wagener, MD
Sturgeon Bay

Editor's note: Dr Wagener points out an important part of a much larger problem—the issue of physicians notifying Medicare patients that they may be responsible for some charges should Medicare deny payment. SMS is working with WPS, the state Medicare carrier, and the AMA and HCFA to resolve this issue. Until a resolution is reached, SMS recommends that physicians use a waiver form for injections for Medicare patients. For more information, contact Patricia Ramsay, SMS Division of Medical Policy and Practice, 1-800-362-9080 or 608-257-6781.—*RDS*

Advertising

TO THE EDITOR: The American College of Allergy and Immunology Board of Regents has lent its support to a resolution passed by the Texas Allergy Society which calls for "truth in advertising" of specialty medical services.

The Board endorsed the concept that "physicians who advertise specialty services but who are not Board certified by the appropriate recognized specialty society board must include a disclaimer in their advertisement to this effect."

I urge the State Medical Society of Wisconsin to accept and seek enforcement of this standard.

—Martin Z. Fruchtman, MD
Waukesha■

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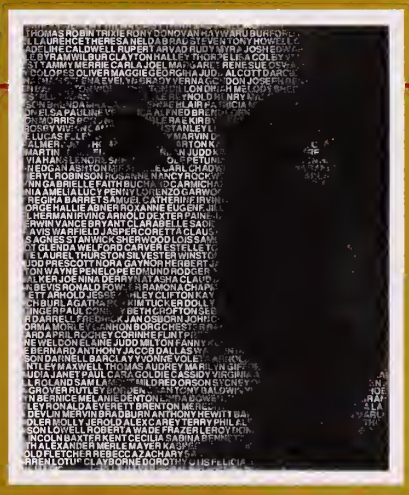

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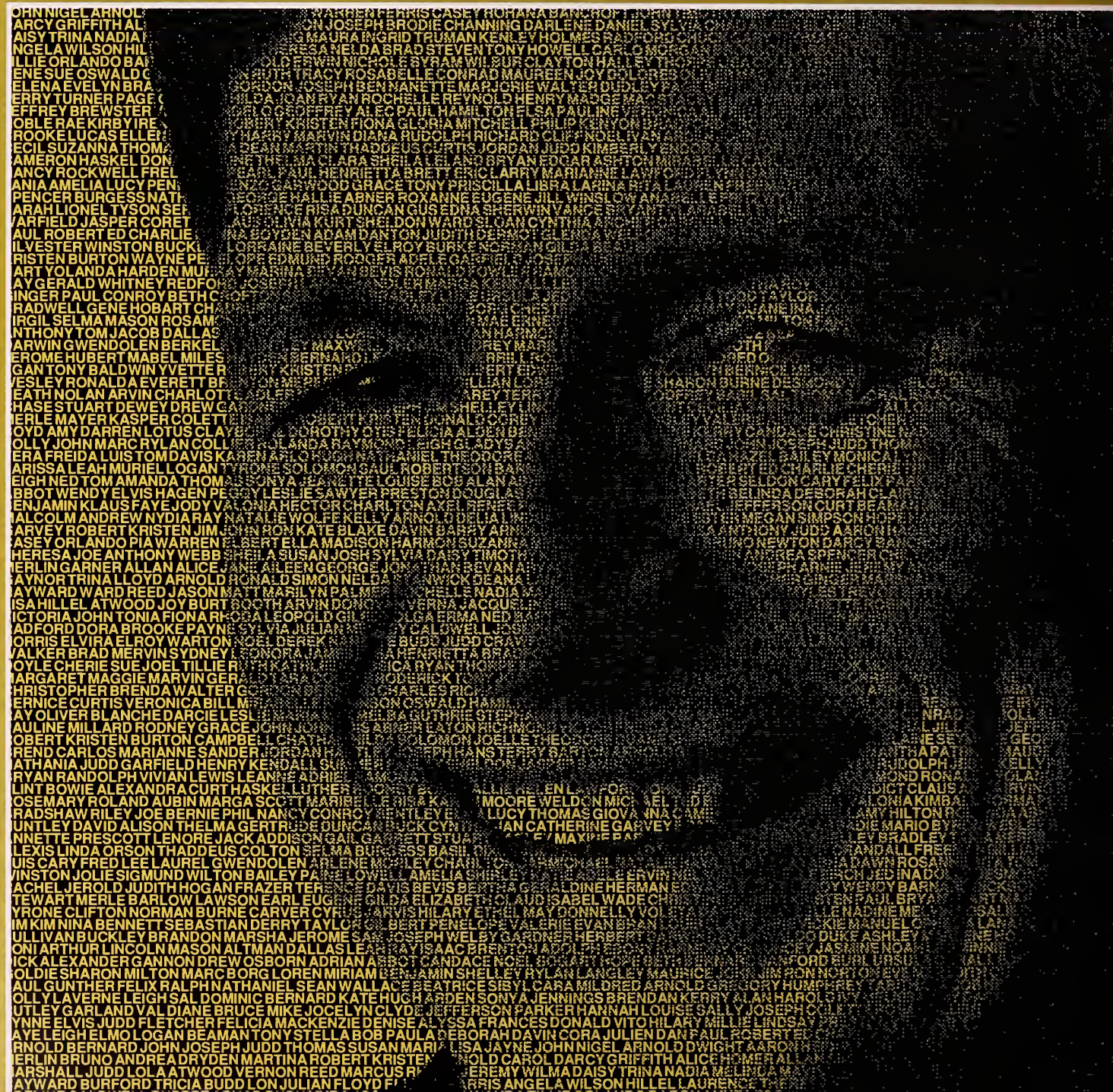

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INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3, and decreasing T_3.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL (propranolol HCl) is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, phenobarbitone, and *rifampin* accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and *lidocaine* have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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Reference:
1. Data on file, Ayerst Laboratories.

D7295/188

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She's gone

R.P. Barthel, MD
Milwaukee

"your mother . . ." they said, and I flew to her side

it looked, what's the word—waxen, wooden, replica came to mind but that implies sameness and that was not true . . .

because she was gone

"a stroke, likely a clot . . ." and I remembered the times

"blow the clots out and let me hold it while we read this book," the dark clumps overflowed the handkerchief and fell to her dress, "don't worry, it will wash away," but now she can't help blow or wash them away . . .

because she's gone

"brain stem . . ." he declared, and now I recognize the evilness that has replaced her

a twig-like spirit, I imagine, deep inside this shell that makes the limbs lie silent or twist in obscene ways. No longer can she ask with touch or voice "What's wrong?" and from miles away my evil spirits would clear but I'm unable to ask her . . .

she's gone

brain stem crackles and startled I leap but the nurse reassures, "just suctioning"

"The doctor and father want to talk to you." I listen and the helpers I've invoked come in their true guise tracheostomy, respirator, she has a right . . . it's simply the will of . . . "No," I scream, but only in my mind, I must stay calm, I have to help them know . . .

she's really gone
will they understand?
would I?

■

Moonlighting

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ABSTRACT. *We surveyed 141 self-selected elderly Wisconsin physicians about their moonlighting practices while in medical training. Forty-four of the respondents (31%) were moonlighters. Many of their activities bespeak a different era;* eg, *three physicians delivered babies, two administered anesthesia, and one assisted in neurosurgery.*

MOONLIGHTING is a secretive but time-honored medical tradition. Through the years, physicians-in-training have donated various body fluids and worked at any available hospital job. Moonlighting physicians continue to cover emergency rooms, wards and clinics, perform physicals, and make house calls.

There seems to be a prohibition about studying moonlighting, for as ubiquitous as it may seem, little is actually known about it. The literature is largely editorial in nature;[1,2,3] and despite several decades of pleas for information, limited data on the actual or historical practice of moonlighting is available. Perhaps the taboo regarding moonlighting results in part from the history of the word 'moonlight.' In the 1500s, moonlighters were those who moved at night to avoid paying rent. The moonlighters of the 1700s were smugglers and prostitutes. In the early 1900s, in Canada, moonlighting began to mean simply working an extra job,[4] but the dark, secret connotation seems to have lingered.

Two recent studies in the *Journal of Medical Education*[5,6] revealed that more than one in three residents surveyed were moonlighters and that moonlighting was related to the presence of educational debt, monthly loan payments, and number of dependents.

The only historical survey data reported are those of Moss, who asked pediatric program directors and members of his own part-time volunteer clinical facility about moonlighting. He found that 70 percent of the program directors permitted moonlighting and 38 of 50 (76 percent) of his facility had been moonlighters. He

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concludes that moonlighters may be in "the silent majority."[1]

To provide an historical perspective, we included a questionnaire on moonlighting in a mass mailing from the Wisconsin Association of Senior Physicians to all Wisconsin physicians over age 60. The survey contained questions regarding their moonlighting practices while in medical training. One hundred forty-one (11.4 percent) of the 1,240 physicians surveyed responded, an unusually high response rate for an association mailing. Thirty percent were 61–65 years old, 31% were age 66–72, and 39% were 73 years or older. Thirty-one percent began their practices during the Depression, 23% during World War II, and 46% after World War II. The mean time in practice of the physicians was 40 ± 0.7 years.

Forty-four physicians (31%) were moonlighters. There was no statistical difference in the frequency of moonlighting in the Depression, World War II, and post World War II groups. If physicians who had been moonlighters chose not to complete the survey because of the taboo, the results would underestimate the frequency of moonlighting in the study population. Moonlighters held 60 different moonlighting jobs during their training years. Fifty of these moonlighting jobs were medical and 10 were nonmedical. The various types of medical moonlighting jobs are listed in Table 1.

Table 1—*Types of moonlighting jobs performed during medical training in the "good old days"*

Hospital externships	7
Emergency room coverage	7
Histories and physicals	6
Vacation coverage for small town physicians	5
House calls	3
Teaching assistant	3
Delivering babies	3
Administering anesthesia	2
Hospital laboratory technician	2
Mental health facility physician	2
Surgical assistant	2
Company physician	2
Diener	1
Postpolio clinic aide	1
Hospital night call coverage during residency shortage	1
Selling blood	1
Hospital bacteriologist	1
Radiologist	1

While covering emergency rooms and performing histories and physicals continue to be moonlighting jobs for today's residents, many of our respondents' medical and nonmedical jobs bespeak a different era. Before residencies became a necessity, externships were the way many physicians-in-training paid their bills. Three moonlighters delivered babies and two administered anaesthesia, blissfully unaware of future malpractice premiums in these specialties. One moonlighter did histories and physicals on Boy Scouts at 50 cents apiece. One worked in a postpolio clinic. Others "assisted a brain surgeon," "took call during a resident shortage," or "sold my blood." The nonmedical moonlighting jobs included: night worker at a soup factory, engineer at a research lab, elevator operator, telephone operator, defense plant worker, cab driver, typist, waiter, bookstore employee, and freightyard worker.

Since the main incentive for moonlighting is economic,[1,5,6] the rising indebtedness of medical students (from a mean indebtedness of $15,421 in 1979–1980 to $26,883 in 1983–1984; 8.2 of 1984 graduating seniors had debts in excess of $50,000)[7] makes it likely that moonlighting activity will increase. While doctors in our study population certainly had financial difficulties during training, they did not have ALAS/PLUS or HEAL loans accruing interest during 3–5 years of postgraduate training. If at least 31 percent of physicians were moonlighters back in the "good old days," it is quite possible that today's increased tuition debts and prolonged postgraduate training have moved moonlighters into "the silent majority."

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Suffer the children

Patients visit their Wisconsin physicians 3.4 times per year, up 3% from the 1983–84 average, according to the 1986–87 Wisconsin Ambulatory Medical Care Survey. The increase represents nearly 570,000 more visits, for a yearly total of 16.3 million.

Nearly three-quarters of the additional visits were for children under the age of 15. At the same time, use of inpatient hospital care showed the greatest decline among children. —*Wisconsin Division of Health*■

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Radon as an environmental hazard in Wisconsin: a basic guide

Melvin S. Blumenthal, MD
Monroe

A TEN-STATE SURVEY completed in 1987 by the US Environmental Protection Agency (EPA) indicated that radon levels in many areas of Wisconsin are higher than previously suspected. Of the approximately 1,200 homes surveyed in Wisconsin, 26% had radon levels higher than the 4 piC/L (picocuries per liter) EPA "action level," and 5% had levels over 10 piC/L. Levels varied throughout the state, but generally were highest in the northeast and along the southern border (see Figure).

Although cigarette smoking has clearly been implicated as the major factor contributing to the development of carcinoma of the lung, a small but significant number of persons who have never used tobacco develop these tumors each year. Recently, evidence has begun to indicate that as many as 25% of lung cancers occurring in nonsmokers may be attributable to radon exposure, with estimates of between 5,000 and 20,000 cases per year in the United States. This incidence compares with about 7,000 cases per year occurring as a result of asbestos exposure.

As long ago as the 16th century, physicians recognized that deleterious pulmonary effects occurred frequently in miners in central Europe. In 1924, lung cancer in these miners was the first internal cancer ascribed specifically to radiation, and subsequent epidemiologic studies in these same miners showed that as many as 50% to 75% of their deaths were from lung cancer. Studies have been complicated by the realization that, at low rates of exposure, the induction or latency time of the tumors may be quite long (20 to 40 years). Nevertheless, the demonstration that, at low doses, the excess risk of exposure is proportional to the cumulative radiation dose has allowed meaningful extrapolations to be made from this occupational data. The radiation dose delivered by the intermediate products of radon decay, or "daughters," is the highest to any body tissue from natural background radiation, and in some geographic areas may account for 50% or more of the total radiation doses received from natural sources.

Radon occurrence

Radium and its sister element, uranium, are almost ubiquitous in the earth's crust, although their concentration may be spotty and irregular. Most soils and rock, especially granite, contain 1 to 4 ppm of uranium. Radium-226 decays to radon-222 by emitting alpha particles, and radon-222 in turn decays through a series of radioactive intermediates, especially polonium-218, to the stable element lead-206. Many of these intermediates, the so-called radon "daughters," also emit alpha particles.

Although alpha particles penetrate human tissue for only a very short distance (about 0.04 mm, or approximately 5 cell diameters), when inhaled they can readily attach to bronchial surfaces in the upper respiratory tract and irradiate the basal stem cells of the epithelial layer. It is the malignant transformation of these cells that is believed to result eventually in cancer in these smaller airways.

Radon gas diffuses through the soil and enters the atmosphere. The gas and its decay products may be carried by air currents or may become attached to aerosols, droplets, and dust before inhalation. Indoors, radon daughter levels have probably been rising for many years, especially in cold climates, as the conversion of stoves and open fireplaces to central heating and the reduced thermal ventilation have increased the "air-tightness" of the modern home. In addition, more of our population spends long periods working indoors, in contrast to the outdoor work habits of the 19th century. Epidemiologic studies have rather consistently shown a higher incidence of lung cancer in urban areas and a lower incidence in rural areas.

Outdoor radon levels are generally low, about 0.2 to 0.3 piC/L, except near areas where uranium mine tailings are present. Indoor levels are much more variable, but composite data from several surveys in the US and Canada have generally shown averages in the 1.0 to 2.0 piC/L range. The 1986-1987 Wisconsin radon survey data showed a mean level of 3.5

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and a median level of 2.3 piC/L.

Radon levels in homes

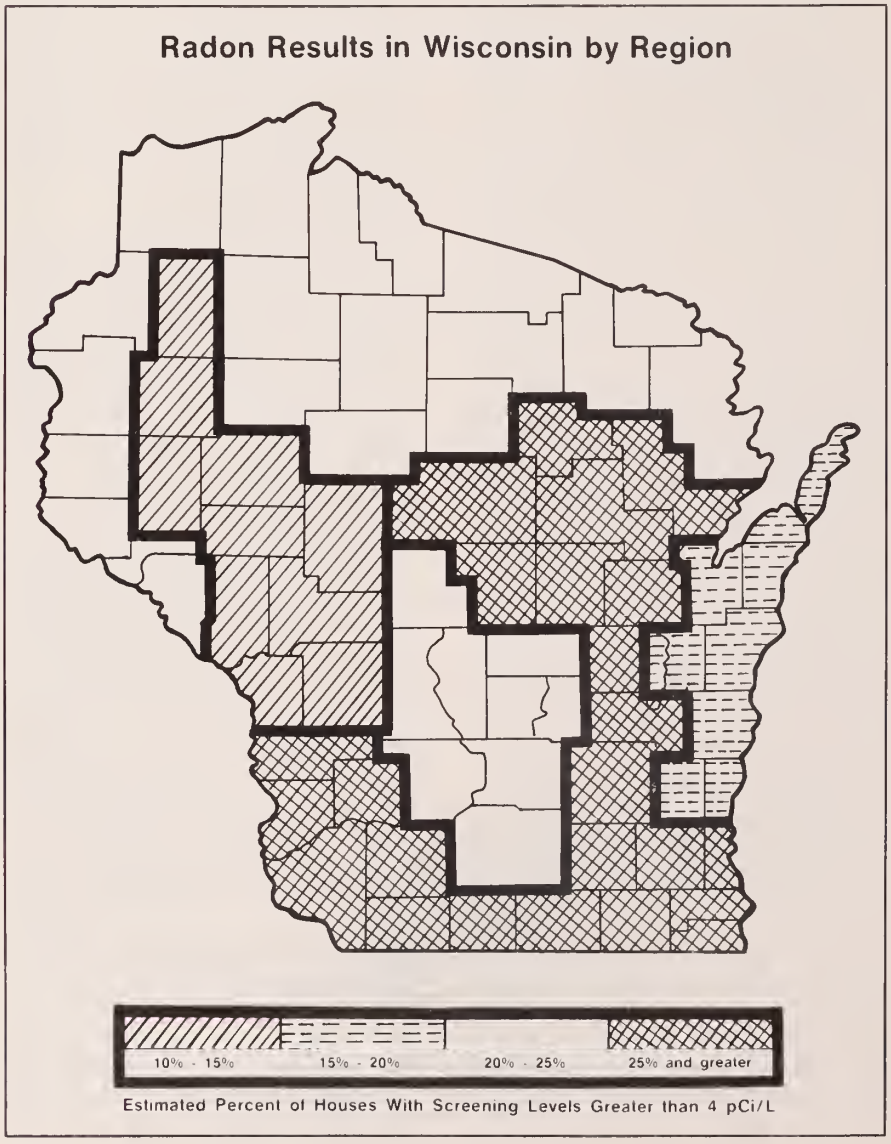
In most homes, the major factor determining the level of radon is the makeup of the earth around and under the house, especially the pressure differential of radon gas between soil and the house. Migration of radon takes place primarily through cracks and penetration points in below-ground walls and slabs rather than diffusion through solid materials. Contributing to this differential pressure are factors relating to ventilation (including the number of air exchanges per hour and the tightness of the house), the habits and activities of the occupants, and aspects of home construction, such as unpaved basements and crawlspaces and the presence of cracks or holes in the foundation or around drains, water pipes, and sump pumps. Unpaved basements permit radon to diffuse readily into living spaces, and radon levels in basements are generally two or three times higher than in other areas of the house. This difference may be increased by keeping doors closed between the basement and the upper floors. Storm windows in the winter and air conditioning in the summer reduce air exchange and may result in higher radon levels. Similarly, cinder-block construction permits diffusion of radon through the home more easily than does concrete.

Building materials per se are believed to contribute only small amounts of radon, although there are occasional exceptions. Gypsum wallboard, stone, and brick have all been made from soils high in radium, and even the rocks used for heat storage in some homes with solar energy systems have been implicated as sources of high residential radon concentrations.

In some areas, especially New England and parts of Pennsylvania, artesian well water may contain significant levels of radon, with a ratio of the radon concentration in water to that in indoor air of 10,000 to 1. The gas escapes from water during washing, bathing, drinking, and cleaning. Public water sources are usually aerated and thus add little to indoor radon levels. Natural gas may also contain high levels of radon, but because the volume used is so low in relation to the volume of a house, this source is not considered important.

Because so many variables contribute to indoor radon levels, surveys have shown wide variations from one locality to another and from one home to another within the same locality. The general conclusions of the ten-state EPA survey were:

- The distribution of radon varied significantly among the different states.
- High radon levels were found in every state that was surveyed. States with the lowest distributions of radon had some houses with extremely high levels.
- The surveys identified certain radon hot spots.
- Geology was generally a good indicator of the presence of high radon areas.



Radon measurement

Because of this variability, radon measurement on a house-by-house basis is necessary to gauge the carcinogenic risk to the occupants.

Radon levels are commonly measured using either a charcoal canister or an alpha track detector. Both are relatively inexpensive ($20 to $50), and a number of laboratories have been certified by the EPA to provide an accurate analysis (for an extensive list of detector sources see "Radon

Detectors," in *Consumer Reports*, July 1987, pp 440-447). The charcoal canister is most commonly used for screening. The canister is left open for three to seven days, and the adsorbed radon is then measured. Because radon levels over this short period may vary widely from day to day, influenced by such variables as changes in ventilation, rainfall, atmospheric pressure, and temperature, a high level should be confirmed with an alpha track detector before major remedial measures are considered. The alpha track detector may be exposed for ten days to one year and, therefore, gives a better estimate of the average radon level over a long period of time.

Concentrations of radon and its decay products are described in terms of either picocuries or the "working-level" (WL), and duration of exposure is described in terms of the "working-level-month" (WLM). The WL is defined as that concentration of radon daughters having a potential alpha energy release of 1.3 x 10^5 meV/L of air. A WLM is equivalent to exposure to an average of one WL for a working month of 170 hours, or about 21 eight-hour days. Living two- thirds of the time in a home with a radon concentration of 1 piC/L would result in an exposure of 0.2 to 0.3 WLM per year.

The health risks

In terms of comparative exposures and risks, an average indoor radon level of 1.0 piC/L (0.005 WL) is equivalent to about 25 chest x-rays per year. A level of 4.0 piC/L (0.02 WL) is equivalent to about 100 chest x-rays per year or to smoking one-third pack of cigarettes per day, and exposure increases the risk of death from lung cancer by three times in a nonsmoker. An exposure to 10 piC/L (0.005 WL) has approximately the same lung cancer risk as a one-pack-per-day smoker, and exposure to 200 piC/L for a long period (20 to 40 years) gives about a 50% chance of developing lung cancer.

Because of the relationship between dose and risk, there is increasing urgency for remedial action at higher home concentrations of radon. It should be emphasized, however, that the EPA guidelines are based on *annual average* radon levels in lived-in areas of the house, not on a single spot screening value obtained with a charcoal canister. Since at least some evidence indicates that radon exposure and cigarette smoking have an additive, or even multiplicative, effect, efforts to discourage smoking in the home are especially appropriate. The EPA has defined the 4 piC/L (0.002 WL) level as the "action level," at and above which definitive measures should be taken "within a few years" to reduce radon levels. The 4 piC/L is also the level to be used as a target for corrective action. For levels between 20 and 200 piC/L, action should be taken "within several months," and above 200 piC/L action is advised "within several weeks." In the 1986-1987 Wisconsin Radon Survey, 1% of the homes surveyed measured above the 20 piC/L level. Because the hazards of a given dose are also proportional to the length of exposure, remedial measures should be begun promptly in homes in which children are living.

Reducing radon exposure

Methods of reducing radon in the home are relatively simple in concept, although they are frequently more complicated in performance. In general, these involve reducing the influx of radon into the home by covering exposed earth and sealing any cracks and openings. In some situations, radon influx may also be reduced by increasing ventilation (by forced ventilation or by increasing natural ventilation), by installing drain-tile suction or sub-slab suction, by preventing depressurization, or increasing below-grade pressurization. The EPA does not endorse the use of air cleaners because none has been shown to be effective in significantly reducing radon levels.

Once a need for radon reduction has been identified, selection of appropriate and cost-effective measures requires a careful home survey by a knowledgeable and honest diagnostician. This survey may involve visual inspection, evaluation of soil gas movement, measurement of air infiltration and exchange rates, and quantification of radon levels in well water. Systems to reduce radon entry can often reduce indoor radon levels by more than 95%, usually at a cost of less than $1,000. The same systems can be built into a new home for $150 to $500.

Tests for radon: availability and funding

The Radiation Protection Section in the Department of Health and Social Services (DHSS) provides information and consultation to persons wishing to test their homes for radon levels. According to John Micka, a radiation consultant with DHSS, the section operates on a limited budget and cannot conduct routine tests of homes. The department will help, however, by providing informational brochures on radon published by the US Environmental Protection Agency (EPA) (see recommended reading list in Dr Blumenthal's article) and a list of EPA-approved manufacturers and suppliers of testing devices. There are currently more than 100 companies on the EPA's list. For additional information, contact: State of Wisconsin, Radiation Protection Section, 5708 Odana Rd, Madison, WI 53719 (phone: 608-273-5180).

The governor's proposed budget for 1988–1989 deleted funding for the half-time radiation consultant position; at publication of this issue of *WMJ*, the legislature had restored the funding, although final budget action had not been taken. The legislative version of the budget would also provide an additional $20,000 in 1988–1989 for the creation of two radon centers, one each in Marathon and Waukesha counties. A bill introduced in the last legislative session to provide $67,000 for the program died when the legislature adjourned in March. The State Medical Society of Wisconsin supports continued state funding for radon-related activities.■

Because high radon concentrations may very adversely affect a home's value, homeowners can become prey to unscrupulous surveyors and repairmen. In the Middle Atlantic states, where the radon problem is both extensive and well publicized, outright fraud has become widespread. The *Wall Street Journal* reported (Sept. 18, 1987) that rip-off artists were selling "vacuum cleaners, mayonnaise jars and fluorescent lights" as radon remedies. Many of these states have passed legislation requiring certification for firms doing remedial radon work.

The public health issue

The problem of radon exposure in the home is assuming increasing importance as a public health issue. Coverage of this problem in the medical literature has been limited primarily to specialized journals not readily available to the average physician in clinical practice. To redress this information gap, the American Medical Association (AMA) Council on Scientific Affairs recommended in its August 1987 report that the AMA join with appropriate governmental agencies in sponsoring conferences on the health effects of radon. The initial conferences were held in the fall of 1987 in Hartford, Conn, Philadelphia, Penn, and Oconomowoc, Wis.

The AMA report also recommended that more extensive surveys be undertaken to study radon levels in representative homes, commercial buildings, and work places across the nation. Publication of the initial ten-state survey by the EPA, which included Wisconsin, underscored the unpredictable distribution of high-radon pockets.

In view of the very large number of persons at risk, local health authorities should consider sponsoring radon surveys in their communities. With estimated deaths attributable to radon of between 5,000 and 20,000 per year in the US, the case for greater involvement by the medical profession is now evident.

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Sequential 5-Fluorouracil, methotrexate, and calcium leucovorin in metastatic colorectal cancer

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ABSTRACT. *Forty-seven patients with metastatic colorectal adenocarcinoma were treated with methotrexate (MTX) 100 mg/m² IV followed one hour later by 5-fluorouracil (5FU) 600 mg/m² IV. Four doses of calcium leucovorin (LCV) 10 mg/m² PO every six hours were given 24 hours after MTX. The regimen was given on days 1 and 8 and repeated every 28 days. Twenty-seven of the 46 patients (59%) had previously received bolus 5FU. Thirty-five patients were evaluable for response and survival rates. One of 35 (3%) obtained partial response, 22 of 35 (63%) experienced disease stabilization, and 12 of 35 (34%) developed progressive disease. The time to progression for previously treated patients was 85 days compared to 156 days for patients who had not been previously treated (P = 0.04, Log-rank test). Median survival from study entry for the 35 evaluable patients was 264 days. Toxicity included severe leukopenia (six, with one death), thrombocytopenia (three), severe stomatitis (nine), and severe renal failure (five). Sequenced MTX-5FU did not improve treatment results in advanced colorectal cancer and resulted in excessive and unacceptable toxicity in this study. At this dosage schedule, sequenced MTX-5FU is not recommended for routine use in the treatment of advanced colorectal cancer.*

Key Words: Colorectal cancer, chemotherapy, leucovorin

A Wisconsin Oncology Group Report. From the Department of Medicine, Medical College of Wisconsin and the Department of Human Oncology, University of Wisconsin Clinical Cancer Center, Madison (D.L.T). Reprint requests to: Richard M. Hansen, MD, Box 133, 8700 W. Wisconsin, Milwaukee, WI 53226, (phone 414-257-4559). Copyright 1988 by the State Medical Society of Wisconsin.

ADVANCED COLORECTAL CANCER continues to be a major medical problem in this country, resulting in more than 50,000 deaths per year in the US and 1,400 in Wisconsin.[1] Fluorouracil (5FU) is the most frequently used chemotherapeutic drug for the treatment of this dis-

Table 1—*Patient characteristics*

Number patients entered	47
Number patients eligible	45
Number evaluable for response	35
Number evaluable for survival	35
Age range in years (median)	34–77 (63)
Number of men/women (ratio)	34:13 (2.6:1)
ECOG performance status	
0	21
1	20
2	5
3	1
$\bar{x}$	0.7
Prior chemotherapy*	27/46 (59%)

*Included bolus 5FU alone or in combination with other drugs in all instances.

ease. Although numerous dosage schedules have been tried, objective response rates have generally been less than 20% and the impact on overall survival minimal.[2,3] Clearly, new strategies are needed to improve treatment results.

Approximately ten years ago, Bertino et al[4] suggested that pretreatment with methotrexate (MTX) might enhance the antitumor effect of 5FU against sarcoma 180 cells in an animal model. Several possible explanations for this synergy have been suggested, and these have been previously summarized.[5] Numerous clinical trials have been reported using sequenced MTX with 5FU in head and neck cancers,[6-10] breast cancer,[11,12] and colorectal cancer.[13-24] In 1983 the Wisconsin Oncology Group initiated the clinical trial discussed here to define further the efficacy and toxicity of sequential MTX with 5FU in advanced cancer.

Methods

Between 1983 and 1985, 47 patients with metastatic adenocarcinoma of the colon or rectum who were at hospitals affiliated with the Wisconsin Oncology Group were enrolled in this study after informed consent was obtained (Table 1). To be included in the study, patients had to have measurable metastatic or locally recurrent adenocarcinoma of the colon or rectum not curable by surgical resection; patients with elevations of carcinoembryonic antigen (CEA) alone were not eligible. In addition, patients had to meet the following criteria:

- between 18 and 75 years of age,
- performance status of 0 to 2 on the Eastern Cooperative Oncology Group (ECOG) scale (asymptomatic to symptomatic but out of bed more than 50% of the time),
- life expectancy of at least three months,
- white bood count WBC≥4,000/dl,
- platelet count ≥1000,000/dl,
- bilirubin <1.5 mg/dl,and
- serum creatine <1.5 mg/dl with creatinine clearance of at least 50cc/ml (eligibility criteria were later changed to serum creatinine <1.2 mg/dl and creatinine clearance >65 cc/min to minimize toxicity.

Patients who had undergone prior chemotherapy were eligible as long as MTX and 5FU had not been used in a timed-sequence schedule; patients with prior radiotherapy were also eligible.

Thirty-four men and 13 women with an age range of 34 to 77 ($\bar{x}=63$) participated in our study. Thirty-six patients had had primary colonic lesions and 11, primary rectal lesions. ECOG performance status ranged from 0 to 3 ($\bar{x}=0.7$)

Treatment consisted of MTX 100 mg/m² IV followed by 5FU 600 mg/m² IV one hour later and four doses of calcium leucovorin (LCV) 10 mg/m² PO every six hours beginning 24 hours after MTX with 5FU. Treatment was given on days 1 and 8 and repeated every 28 days unless toxicity occurred. Patients did not receive routine intravenous hydration, urine alkalinization or monitoring of MTX levels, and no other antineoplastic therapy or concomitant radiotherapy was given during the study period.

Efficacy was assessed using standard criteria. These were:

- complete response—disappearance of all tumor and normalization of abnormal tumor parameters for at least two months' duration,
- partial response—50% or more reduction in tumor volume (the product of greatest perpendicular diameters) for a duration of at least two months, stable disease—less than 50% reduction or an increase of 25% or less in tumor volume for at least two months' duration,and
- progressive disease—more than 25% increase in tumor volume or the development of new sites of disease.

Although CEA was serially evaluated in some patients, it was not used alone to evaluate response to therapy. To be considered evaluable for

Table 2—*Results (n=35)*

	Complete response	*Partial response*	*Stable disease*	*Progressive disease*
Prior 5FU	0	0	11 (31%)	8 (23%)
No prior 5FU	0	1 (3%)	11 (31%)	4 (11%)
Total:	0	1 (3%)	22 (63%)	12 (34%)

Table 3—*Toxicity (n=45)*

	None	*Mild*	*Moderate*	*Severe*	*Life-Threatening*	*Lethal*
White blood count effects	25	10	3	1	4	1
Platelet count effects	35	3	3	0	3	0
Hematocrit	29	8	5	2	0	0
Nausea and vomiting	26	7	9	2	0	0
Neurologic	26	14	3	1	0	0
Dermatitis	36	3	2	3	0	0
Stomatitis	27	5	3	8	1	0
Renal failure	40	0	0	2	3	0

Hematologic toxicity definitions:
Anemia: mild—Hgb 9.5-10.9 gm%; moderate—Hgb <9.5 gm%; severe—requires transfusion.
Thrombocytopenia: mild—90-130×10³; moderate—50-90×10³; severe—25-50×10³; life-threatening— <25×10³.
Leucopenia: WBC 3.0-4.5×10³; moderate—2.0-3.0×10³; severe—1.0-2.0×10³; life-threatening— <1.0×10³.

response, patients had to complete at least two cycles of treatment. Survival statistics were calculated using both Logrank and Wilcoxon methods.

Results

Although 47 patients were included in this study, only 35 were evaluable for response for the following reasons:

- One patient was never treated.
- One committed suicide after four days on study.
- Seven completed less than one cycle of treatment due to toxicity.
- One patient refused treatment.
- One completed less than two cycles of treatment due to progressive disease.
- Inadequate data were reported on one patient.

Treatment results are presented in Table 2 and are stratified according to previous 5FU administration. One of 35 patients (3%) attained partial response, 22 (63%) had stable disease, and 12 (34%) experienced progressive disease. Of the 16 previously untreated patients, one (6%) attained partial response, 11 (69%) had stable disease, and four (25%) developed progressive disease. Median time to progression for the entire group was 113 days (range, 23 to 373). Median time to progression for patients who had previously received 5FU was 85 days compared to 156 days for patients who had not. Time to progression was significantly longer for those patients who had not received 5FU ($P=0.04$, Logrank method). Median survival from study entry for the 35 evaluable patients was 264 days (range, 26 to 854) with a median of 214 days for patients with prior 5FU and 303 days for patients without. No significant difference in survival times was found (P, NS).

Toxicity data and their definitions are summarized in Table 3. Data from 45 of the 47 patients is available for analysis. The majority of patients experienced no toxicity. The toxicity that did occur, however, was severe and included: leukopenia (six, including one death), thrombocytopenia (three), stomatitis (nine), and renal failure (five).

Discussion

The overall prognosis for patients wih advanced colorectal cancer is poor because of a relative lack of effective chemotherapeutic agents. Although 5FU is the most frequently used antineoplastic drug, response rates have been low and its impact on survival minimal. Based on the in vitro synergism reported by Bertino,[4] numerous investigators have attempted to potentiate the antitumor effect of 5FU by pretreatment with MTX.[6-24]

The optimal drug dosage of MTX to potentiate 5FU for clinical administration has not been defined. In this study, MTX was given at 100 mg/m^2, and our results are similar to others in which the dose of MTX was between 40 and 100 mg/m^2.[14,21,23] Some investigators have increased the dose of MTX to 160 to 250 mg with the same time interval and essentially the same dosage schedule of 5FU without appreciable improvement in response rates.[7,18,25,26] Other trials have used both higher doses of MTX and 5FU and longer sequencing intervals (four to seven hours) between the two drugs with varying results.[12,15-17,19,20] Whether apparent improvement in response rates is secondary to increased drug dosage or prolonged treatment interval is unclear.

It should be emphasized that as the dose of MTX is increased, the possibility of potentially life-threatening toxicity is likewise increased.[12,26] In general, MTX at the dosage we used is considered relatively safe for administration in the outpatient setting without extensive hydration, alkanlinization of urine or measurement of MTX levels provided that renal function is adequate. The complications we encountered, however, demonstrate that at even relatively modest doses, MTX can cause serious and even life-threatenineg toxicity if it is not adequately excreted because of such conditions as dehydration, partial ureteral obstruction, or concomitant urinary tract infection. If higher doses of MTX are found to be more effective at potentiating 5FU, the situation would become even more complicated.

The scheduling interval between MTX and 5FU for colorectal adenocarcimoma also remains empirical. The original observations by Bertino suggest that a more optimal scheduling interval might be as long as four or more hours. Although several studies have examined intervals of four to 24 hours,[12,15,16,19-24] these sequencing intervals impose logistical problems in the clinic. Further sequencing studies are needed to determine whether changing the interval between MTX and 5FU administration alters the response rate before this approach can be recommended as routine treatment. Finally, any MTX-5FU sequencing study in colorectal cancer that suggests improved results should be tested in a prospective randomized trial in view of three recently reported negative prospective randomized studies of MTX-5FU in head and neck cancers,[8,9,11] and three in colorectal cancer.[21,22,28]

In conclusion, sequenced MTX, 5FU and LCV at the dosage schedule in our study did not improve the response rate in colorectal cancer compared to historical results obtained with 5FU alone. In addition, patients experienced excessive and unacceptable toxicity. Consequently, this treatment regimen is not recommended for routine use in patients with advanced colorectal cancer.

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Streptokinase therapy for acute myocardial infarction

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ABSTRACT. ***Data from 435 patients evaluated for possible thrombolytic reperfusion therapy for acute myocardial infarction were retrospectively analyzed. Of these patients, 110 patients underwent acute catheterization only, 120 received intracoronary streptokinase, 57 received intracoronary streptokinase in combination with percutaneous transluminal coronary angioplasty, 25 received PTCA only, and 123 patients received intravenous streptokinase therapy. The results indicate that aggressive early treatment of the acute myocardial infarction patient was accomplished at very low morbidity and mortality rates. No clear-cut advantage of either intravenous or intracoronary therapy over the other was present for salvage of myocardium or prevention of death. All patients receiving IV thrombolytic therapy should have elective cardiac catheterization early post-MI to assess the coronary anatomy and provide appropriate therapy to prevent re-occlusion, reinfarction and sudden death.***

Key Words: Myocardial infarction, streptokinase, intravenous, intracoronary, tertiary care center.

From the Appleton Heart Institute. Reprint requests to: Lowell F. Peterson, MD, Appleton Heart Institute, 820 Grant St., Appleton, WI 54911 (phone 414-731-8900). Copyright 1988 by the State Medical Society of Wisconsin.

THE DECLINE IN mortality from acute myocardial infarction (MI) in the past 25 years has been attributed in part to decreased case fatality rates secondary to better therapy.[1] The advent of the coronary care unit and the use of new pharmacologic interventions have led to improved survival and diminished ischemic injury following MI. In a review on myocardial protection, however, Braunwald and Maroko[2] stated, "It stands to reason that no form of medical intervention is likely to be as effective in preserving myocardial cells as the restoration of blood flow to the obstructed vessel."

Osler[3] in 1910 and Herrick[4] in 1912 described sudden death related to thrombosis of a coronary artery, but it was not until 1980 that DeWood[5] demonstrated the presence of a thrombus as an etiology in more than 80% of acute MI patients. The first effective use of thrombolytic therapy for acute MI was reported by Rentrop[6] in 1979. It has since been shown that thrombolytic reperfusion of obstructed coronary arteries early in the evolution of MI limits infarct size, preserves left ventricular function, and reduces early mortality.[7-11] The single most important determinant of beneficial reperfusion is the duration of time from onset of symptoms to reperfusion.[12] Intravenous (IV) thrombolysis has the advantage of being readily available for prompt early administration in urban and rural hospitals, whereas, intracoronary (IC) thrombolysis, although more effective, requires access to a skilled catheterization laboratory in a tertiary referral center. This report retrospectively analyzes a consecutive series of patients from urban and rural areas in northeastern Wisconsin served by a tertiary referral

Table 1—*Total Population*

	Catheterization	*IV-STK**
Total patients	312	123
Men	237 (76%)	84 (68%)
Women	75	39
Age range	31 to 81	28 to 79
Mean	58.3	58.5

*Intravenous streptokinase

center who received intracoronary streptokinase (IC-STK) for early MI and compares these findings to a series of patients from the same area treated in their local hospital by intravenous streptokinase (IV-STK).

Method

Between October 1981 and January 1987, 312 patients underwent acute catheterization at the Appleton Heart Institute for suspected MI (Table 1). Of this group, 120 patients received IC-STK as their only acute therapy. Between September 1983 and January 1987, 123 patients received IV-STK as acute thrombolytic therapy in local hospitals served by this referral center. All patients had chest pain of less than six hours' duration in spite of conventional antianginal therapy and had no exclusionary criteria for the use of STK therapy. The electrocardiogram (EKG) criterion was a greater than 1 mm ST elevation or depression in two contiguous leads. All IC-STK patients received IC or sublingual nitroglycerin, IV methylprednisolone sodium succinate, and IV heparin premedication in the catheterization laboratory. An IC bolus of 10,000 units STK was followed by infusion of 2,000 to 5,000 units of STK per minute for up to 90 minutes. The infusion was terminated when adequate perfusion was achieved or an alternate form of therapy was chosen, ie, coronary care unit (CCU), coronary artery bypass grafting (CABG), or percutaneous transluminal coronary angioplasty (PTCA). The IV-STK group all received 1.5 million units of STK over 30 to 60 minutes intravenously in the ICU.

Results

The IV-STK group is compared to the IC-STK group in Table 2. End points in the IV-STK group suggesting reperfusion included 45 patients (37%) with ST return to normal and 73 patients (59%) with total chest pain relief during the infusion. There were 93 patients (76%) who subsequently had cardiac catheterization, and 67 of these patients (72%) had a patent infarct vessel.

The therapy and success rate of the acute catheterization population is presented in Table 3. The number of patients successfully reperfused with the IC-STK alone was 83 (69%). Another 36 patients were successfully reperfused with IC-STK, but also had PTCA acutely for a total of 119 of 156 patients (76%) successfully reperfused by IC-STK in the catheterization laboratory. These latter patients were not included in the comparative figures of this study because many of them had slow, ineffective forward flow postreperfusion prior to the PTCA.

It is difficult to assess the left ventricle during acute MI because of the phenomenon of "stunning." A subsequent evaluation of the IC-STK population by nuclear left ventricu-

Table 2—*Major comparative features*

Total patients	*IC-STK** 120	*IV-STK†* 123
MI Inferior-posterior	65 (54%)	73 (59%)
MI Anterior	50 (42%)	46 (38%)
MI Other Site	5 (4%)	4 (3%)
Morbidity	22 (18%)	42 (34%)
Mortality	5 (4%)	9 (7%)
Emergency CABG‡	25 (21%)	0 (0%)
Elective CABG	43 (36%)	36 (29%)
Medical therapy or PTCA§	52 (43%)	56 (46%)
Hemorrhage	3 (2.5%)	12 (10%)
CVA	3 (2.5%)	1 (0.8%)

*Intracoronary streptokinase
†Intravenous streptokinase
‡Coronary artery bypass graft
§Percutaneous transluminal coronary angioplasty

Table 3—*Success rate and subsequent disposition*

	Total patients	*Success rate*	*Emergency CABG**	*Medical therapy*	*Elective CABG*	*Elective PTCA*	*No specific*
STK	120	S‡-83	25	47	43	5	0
AC‖	110		32	36	25	2	15
STK-PTCA†	57	S (B)-22‡‡ U (B)¶-17 S(STK) + U(PTCA)-14 U(STK) + S(PTCA)-4	3	42	10	0	2
AC-PTCA	25	S-14 U-11	4	18	2	1	0
TOTAL	312		64	143	80	8	17

*Coronary artery bypass graft
† Percutaneous transluminal coronary angioplasty
‡ Successful
§ Unsuccessful
‖Acute catheterization
¶ Both

lar angiography later revealed an ejection fraction range from 12% to 78%, with a mean of 47%, in those patients successfully reperfused by IC-STK. Data were available on only 57% of the IC-STK patients, however. Forty-one patients (44%) had an akinetic infarct site and, therefore, no visible myocardial salvage by the IV-STK therapy. There were, however, 34 patients (37%) who had hypokinesis and another 11 patients (12%) with no left ventricular abnormality for a total of 45 patients (48%) who had apparent myocardial salvage related to the IV-STK therapy.

The mortality rate was 4% in the IC-STK group and 7% in the IV-STK group. Morbidity was 18% in the IC-STK group and 34% in the IV-STK group. In the IV-STK group, 10% had significant bleeding and one patient had a CVA. Only three patients (2%) had significant bleeding and three (2%) had CVA in the IC-STK group.

The percentage of patients from each group receiving elective CABG was similar and, of course, no patients in the IV-STK group received emergency CABG. Twenty-five patients (21%) in the IC-STK group received emergency CABG. Seventeen of these patients had been successfully reperfused by the IC-STK and eight were unsuccessful. Most of these patients had severe three-vessel coronary artery disease or remained unstable and were not felt to be candidates for PTCA.

Conclusions

The IV-STK and IC-STK groups studied were both heterogeneous and were derived from the same population base in the same area of the state served by the same hospitals. The age range, mean age, and sex distribution were similar in the two population groups. The site of the MI was also similar. Left ventricular salvage was difficult to evaluate, but clearly showed successes and failures of myocardial salvage in both groups. Patients with successful reperfusion did not always have myocardial salvage.

The mortality rate overall was similar in the two groups, but the morbidity rate was clearly different. Most of the morbidity in the IV-STK group, except for hemorrhage, was minor and related to quickly reversible arrythmia situations that occurred during the infusion and reperfusion. Morbidity from IC-STK was often related to the catheterization procedure itself or to surgical complications in patients referred to emergency CABG. These tended to be more serious complications.

It is interesting to note that the IC-STK group was much more likely to receive CABG (57%) compared to the IV-STK group (29%), which was almost entirely related to patients in the IC-STK group receiving emergency CABG. This probably indicates that in every MI population meeting criteria for use of thrombolysis, there is a group of patients, perhaps 20% to 30%, who clinically and anatomically appear to be candidates for emergency CABG or PTCA. It is, however, difficult to look at the mortality and morbidity figures as well as left ventricular salvage and state convincingly that a significant difference occurs in the in-hospital outcome to justify the transfer of these patients to tertiary care hospitals for expensive and time-consuming catheterization procedures and even more expensive intervention with PTCA or CABG on an acute basis.

The time of administration of STK clearly favors the IV route in almost all situations, particularly in the rural hospital ($\bar{x} = 3$ hours). For these patients, the catheterization laboratory in the tertiary hospital is most effectively used to define residual coronary artery disease and provide definitive PTCA or CABG therapy on an early, but elective basis, to prevent reinfarction, reocclusion, angina, and sudden death.[13] Patients arriving early at the tertiary hospital, however, may have a clear-cut advantage from acute catheterization, which provides the cardiologist with the options of intracoronary thrombolysis, acute PTCA or acute CABG.

A new (and expensive) thrombolytic agent, tissue plasminogen activator (t-PA), which was recently released by the FDA, is more fibrin-specific than STK.[14] Initial results suggest that IV-TPA can lead to recanalization at rates similar to IC-STK.[15-18] The role of this agent and of acute PTCA for early therapy of MI is now evolving and will be more clearly defined in the near future.

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Comment

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The paper by Peterson et al purports to show that "an aggressive early treatment approach to the acute myocardial infarction patient was accomplished at a very low morbidity and mortality rate." The authors also state, "No clear-cut advantage of either intravenous or intracoronary therapy over the other was present for salvage of myocardium or prevention of death." Analysis of the authors' tabular data shows a combined morbidity-morbidity complication rate for the group of patients treated with intracoronary streptokinase of 27.5% and for the group treated with intravenous streptokinase of 52.3%.

The advantage of intravenous over intracoronary streptokinase in a community hospital setting was demonstrated in a previous study not cited by Peterson.[1] Similar results were shown in another study using tissue plasminogen activator in the community hospital setting.[2] A reason for this advantage includes the ability to give thrombolytic therapy soon after the onset of myocardial ischemia. Intravenous thrombolytic therapy can reduce the time from the onset of acute myocardial infarction to treatment and improve the rate of successful thrombolysis. In addition, intravenous use makes thrombolytic therapy available to more patients, since facilities and personnel needed to perform cardiac catheterization are not immediately needed. It cannot be determined in Peterson's study what the time was from onset of acute myocardial infarction to the initiation of therapy or what the reperfusion rate was in each of his groups of patients.

Assessment of myocardial salvage has been an area of controversy since forms of therapy have been devised to reduce myocardial infarct size.[3] Peterson performed a "subsequent evaluation" of only 57% of the group of patients treated with intracoronary streptokinase using nuclear left ventriculography "later in the hospitalization." This group was analyzed neither with regard to reperfusion nor matched with a control group. It would be difficult to make conclusions regarding myocardial salvage from these data.

Finally, since tissue-type plasminogen activator has been released by the Food and Drug Administration for use in acute myocardial infarction, streptokinase may now be obsolete. Use of tissue-type plasminogen activator, although more costly than streptokinase, has a decided advantage regarding rates of reperfusion particularly when thrombolytic therapy is begun more than two to three hours from the onset of infarction.[4]

In summary, despite the conclusions by Peterson, et al, it still appears to be more efficacious and safer to give thrombolytic therapy in the community hospital where a patient first presents with acute myocardial infarction than to transport that patient when unstable to another facility. The strategy of then admitting that patient for a period of 24 to 48 hours, during which time reperfusion with its accompanying arrhythmias has occurred, seems prudent. Subsequently, the patient can be transferred to another hospital, when stable, for further evaluation and treatment, which might include cardiac catheterization and intervention with percutaneous transluminal coronary angioplasty or coronary bypass surgery.[5,6]

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Comment

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The authors imply that their article is not a quantitative study but rather a qualitative one describing their experience. No attempt is made to claim that a statistically significant conclusion can be reached on the basis of reading this article.

It is useful to understand that Wood demonstrated thrombus is present in 80% of acute MI patients when the catheterization is done. The presumption is not that the thrombus is responsible for causing MI in 80% of patients, but that spontaneous thrombolysis is occurring in 20% of patients. Therefore, it is important to keep in mind that intravenous streptokinase patency rates will appear falsely optimistic when the angiogram is done following the administration of the IV streptokinase. This is pointed out in the TIMI study in which the success rate of IV streptokinase is approximately 45% (the angiogram is performed before the administration of IV streptokinase) rather than the 72% noted in this article.

Additional insight into the value of early thrombolysis with subsequent angioplasty and CABG surgery can be gained by reading the articles published by the working group on thrombolytic therapy in acute myocardial infarction of the Netherlands Interuniversity Cardiology Institute. These articles are published in the *Journal of the American College of Cardiology*, April 1986,7:717 and 729-743. These articles, plus the GISSI study in *Lancet*, Feb 22, 1986: 397-402, show a definite benefit from the appropriate use of intravenous thrombolytic therapy.

The TIMI study seems to show that intravenous tissue plasminogen activator is more effective and less toxic than intravenous streptokinase.

In our own institution, we are treating patients who arrive with evidence of acute myocardial infarction under six hours of duration with either intravenous tissue plasminogen activator or emergency angioplasty.

A community hospital without a catheterization laboratory that

has extensive experience in angioplasty should institute therapy to appropriate patients with a thrombolytic agent.

At the present time, it is not absolutely clear whether emergency angioplasty (within one hour of the patient's admission) or emergency thrombolysis is the better form of therapy.

Unstable patients who need extensive intervention with intra-aortic balloon pumps, etc are better treated with emergency angioplasty when that is immediately available.■

CLINICAL CANCER: Number 24 of a series

Systemic therapy of colorectal cancer

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DESPITE INCREASING EMPHASIS on prevention and early detection, advanced colorectal cancer continues to be a major health problem in this country. Each year, more than 50,000 persons in the US and 1,400 in Wisconsin die from colorectal cancer.

Metastatic disease

Fluorouracil (5FU), either alone or in combination with other drugs, is the most frequently used treatment for advanced colorectal cancer (Table 1) (Editor's note: An article by Dr. Hansen and his colleagues at the Wisconsin Oncology Group reporting on their study of 5FU also appears in this issue). Traditional methods of administration have included several different bolus schedules; reported response rates have varied widely depending on the criteria used to assess response. Most oncologists feel, however, that the response rate for bolus 5FU alone is between 8% and 20%. In general, higher dose schedules result in higher response rates, but also higher rates of toxicity and an occasional drug related death. Unfortunately, higher response rates have not translated into a meaningful prolongation of survival.

Numerous combination regimens using nitrosoureas, streptozotocin, mitomycin, vincristine, and other drugs with 5FU as a backbone have been evaluated. Although preliminary reports frequently suggest improved response rates, subsequent evaluations with larger numbers of patients generally fail to corroborate improved results compared to 5FU alone.

Based on the observation that pretreatment with methotrexate (MTX) enhanced the antitumor effects of 5FU in an animal model, numerous clinical trials investigated timed-sequenced MTX, 5FU, and leucovorin (LCV). In general, MTX was given one or more hours before 5FU, and LCV was given 24 hours after 5FU as an antidote to prevent MTX toxicity. Although some studies have shown apparent improvement in response rate compared to historical data for bolus 5FU alone, randomized controlled trials have shown no improvement in response rate or survival compared to bolus 5FU alone. Many investigators are now evaluating the role of high-dose LCV without MTX to potentiate bolus 5FU. Preliminary results suggest higher response rates compared to 5FU alone. In addition, one tightly controlled study demonstrates a significant difference in both response rate and survival in favor of 5FU with LCV.[1] However, there are few complete responses reported, and it does not appear that patients progressing on bolus 5FU alone can be salvaged with the addition of LCV after disease progression.

Improvements in venous catheter composition and advances in ambulatory pump technology now allow widespread use of prolonged outpatient venous infusion chemotherapy. Administration of 5FU as a protracted venous infusion appears to improve the response rate compared to the use of bolus 5FU alone.[2] The Mid Atlantic Oncology Program (MAOP) has recently corroborated this in a prospective randomized trial[3] in which 5FU by protracted in-

Dr Hansen is an associate professor in the Department of Medicine at the Medical College of Wisconsin. Reprint requests to: Richard M. Hansen, MD, Box 133, 8700 W. Wisconsin, Milwaukee, WI 53226 (phone 414-257-4559). Copyright 1988 by the State Medical Society of Wisconsin.

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Physicians are encouraged to contact the authors if they wish to discuss these topics further or obtain additional information. Comments or suggestions for topics would be welcome.

Table 1—*Summary of studies using fluorouracil in advanced disease*

Drug	*Response Rate (%)*	*Median Survival (mos)*
Bolus 5FU	8 to 25	6 to 10
Bolus 5FU plus combinations	5 to 40	7 to 10
Bolus 5FU plus sequential MTX* and LCV†	5 to 40	7 to 10
Bolus 5FU plus LCV	30 to 40	11
Infusion 5FU	30 to 40	11
Infusion 5FU plus MTX/LCV	0	0
Infusion 5FU plus DDP‡	63	12

*methotrexate
†leucovorin
‡cisplatin

fusion produced a 30% response rate compared to 8% for bolus 5FU. Although there was no difference in median survival, there was a projected survival advantage at two years in favor of infusion therapy. After progressing on bolus 5FU, some patients were crossed over to infusion 5FU with secondary responses. This may have obscured differences in survival.

The addition of MTX and LCV to 5FU infusion produced excessive mucosal and dermatologic toxicity and is not recommended. Some investigators are using weekly low-dose cisplatin (DDP) to potentiate 5FU infusion.[4] In a preliminary report, 20 of 32 patients (63%) with colorectal cancer responded. Although these results are encouraging, they are highly preliminary and need corroboration. Prospective randomized trials currently being conducted by the MAOP and the Eastern Cooperative Oncology Group (ECOG) will assess the role of DDP potentiation with 5FU infusion.

Intra-arterial therapy

In approximately 30% of patients with metastatic colorectal cancer disease is largely confined to the liver. Although an occasional patient will have metastases amenable to surgical resection, most patients are inoperable. More than two decades ago, physicians first tried intrahepatic infusion of chemotherapeutic agents, and since then more than 900 patients have been reported in uncontrolled trials. Response rates have varied between 30% and 88% depending on the criteria used to assess response. Only recently have well-designed prospective controlled trials been initiated (Table 2.) Preliminary results from the Northern California Oncology Group (NCOG)[5] and Memorial Sloan-Kettering Cancer Center (MSKCC)[6] both showed significant improvement in response rates when floxuridine (FUDR) was infused directly into the liver via an intra-arterial catheter compared to systemic venous infusion. Although response rates appear to favor intra-arterial therapy, to date neither study shows statistically significant differences in overall survival rates. Potential survival differences may be partially obscured because some patients were crossed over to intra-arterial therapy with secondary responses after disease progression on systemic therapy.

Intra-arterial chemotherapy may cause severe toxicity, including chemical gastritis and potentially fatal sclerosing cholangitis. Improvements in catheter placement and lower drug dosages have decreased these complications. In view of the toxicity and lack of survival differences thus far, we must await completion of these ongoing randomized trials before concluding that intrahepatic infusion of chemotherapy is indicated on a routine basis for patients with liver-dominant metastases.

Table 2—*Intrahepatic therapy—randomized studies*

	Response	*Survival*
Northern California Oncology Group		
IV* (n = 59)	6 (10%)	NS‡
IA† (n = 51)	19 (37%)	NS
Memorial Sloan-Kettering Cancer Center		
IV (n = 40)	9 (23%)	NS
IA (n = 39)	18 (46%)	NS

*Intravenous (systemic) floxuridine (FUDR)
†Intra-arterial (intrahepatic) FUDR
‡No statistically significant difference

Table 3—*Adjuvant chemotherapy in controlled trials*

Group	*Number of Patients*	*Statistical Improvement in Survival*
VASAG* (combined studies)	>1400	no
COG† (colon)	149	no
COG (rectal)	61	yes‡
GITSG§ (colon)	621	no
GITSG (rectal)	227	yes‡
NSABP** (colon)	1166	yes‡
NSABP (rectal)	528	no

*Veterans Administration Surgical Adjuvant Group
†Central Oncology Group
‡see text
§GI Tumor Study Group
**National Surgical Adjuvant Breast Project

Adjuvant therapy

Chemotherapy to prevent recurrence after surgical resection has been extensively evaluated (Table 3). Most studies used bolus 5FU either alone or in combination with other chemotherapeutic drugs or immunomodulating drugs. Although some studies show improvement in disease-free interval compared to no treatment, most fail to show any statistically significant improvement in overall survival rates.[7-9] One exception was the relatively small clinical trial reported in 1979 by COG.[10] Patients with rectal cancers who received chemotherapy had significant improvement in survival. However, the same benefit could not be demonstrated in the larger colon cohort of patients. In contrast, the recently report National Surgical Adjuvant Breast Project (NSABP) trial demonstrated a statistically significant increase in five-year survival for those patients who received 5FU, methyl-CCNU, and vincristine compared to an untreated control group in patients with colon cancer.[11] The companion NSABP rectal study did not, however, demonstrate a similar beneficial effect from chemotherapy.[9] Finally, the rectal study performed by the GI Tumor Study Group (GITSG) did not demonstrate enhanced survival when originally

published.[8] However, subsequent analysis of the data demonstrated enhanced survival in those patients receiving chemotherapy, especially for those who also received radiation therapy.[12] In contrast, the NSABP was unable to demonstrate any survival advantage in patients receiving chemotherapy with or without irradiation.[9]

In view of the many negative previous studies, the inconsistency between the large cooperative trials, and the potential for long-term toxicity from these chemotherapy drugs, routine use of chemotherapy in the adjuvant setting is not recommended. Whenever possible, patients should be entered into investigative protocols evaluating new adjuvant treatments.

Current investigative adjuvant studies include 5FU with LCV (NSABP), portal vein infusion (NSABP), 5FU infusion (MAOP), and 5FU with levamisole (intergroup). These trials are ongoing, and no data are yet available. Routine adjuvant use of these treatments in a non-study setting is not currently recommended.

Summary

Systemic therapy for colorectal cancer with bolus 5FU has been ineffective and in combination with other drugs has been largely disappointing. However, current results using bolus 5FU with high-dose LCV are promising and need further investigation. Administration of 5FU by protracted infusion also improves the response rate. Patients failing on bolus 5FU may receive secondary benefit when treated by protracted infusion. The addition of weekly low-dose DDP to potentiate 5FU infusion is being actively investigated.

Selected patients with liver-dominant metastases may benefit from intrahepatic chemotherapy. Significant toxicity may occur, however, and randomized studies to date have not shown a significant difference in survival. We must await results of these current ongoing clinical trials before routine use of intra-arterial therapy is recommended.

Adjuvant bolus 5FU alone or in combination with other drugs has not produced statistically significant improvement in survival in most studies, and its routine use is not recommended. Current investigative studies evaluating adjuvant 5FU infusion and bolus 5FU with LCV are in progress, but we must await their results before these treatment modalities can be recommended for routine use.

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Lyme disease: a seasonal reminder

LYME DISEASE is an infectious disease which results from the bite of a certain species of tick. It often starts out as a skin rash and can occasionally progress through different stages to involve arthritis, skin disease, and neurologic disease. The symptoms and various presentations of the disease are becoming much more commonly recognized; and when detected early, the disease can be treated with antibiotics.

CAUSE: Lyme disease is caused by a spiral bacteria (a spirochete, pronounced "spy-row-keet") called Borrelia burgdorferi, named after its discoverer, Doctor Burgdorfer, who identified the bacteria inside the bodies of ticks.

The disease was first described in Lyme, Connecticut in 1976 and was named after that town. The tick which transmits the bacteria is called Ixodes dammini (pronounced "x-o-deez dam-in-eye") and is generally smaller than the common wood or dog tick. The tick lives in grassy and wooded areas and feeds on both large and small animals.

Between 10% and 65% of the ticks, depending on the area, may harbor this bacteria. When the tick bites, the bacteria sometimes is passed into the bloodstream of animals where it multiples and may be taken up by other blood-sucking ticks or insects. Most animals do not have symptoms that appear in humans, although dogs may sometimes have arthritis.

The tick is found throughout central Wisconsin and in other areas of the United States, including coastal Delaware, Massachusetts, Minnesota, California, and

Editor's note: Because spring and summer are the seasons of highest risk for tick bites, the *Wisconsin Medical Journal* offers this reminder on Lyme disease. This article first appeared in the July 1986 issue of the *Journal*. Reprints, on poster board for reception areas, are available upon request from: Ron Henrichs, Division of Communications, State Medical Society of Wisconsin, PO Box 1109, Madison, WI 53701; phone 608-257-6781.■

Texas. The ticks prefer wooded areas and adjacent grassland. Generally it is spread in the wild by animals (birds, mice, raccoons, and deer), but domestic animals, such as cats, dogs, and horses, can carry the ticks closer to home.

Your chance of tick bite varies with the seasons of the year, and the highest risk is from May to mid or late August. There is a moderate risk from mid April to early May and from late August through October.

The tick bite itself is generally not painful, and the tick is so small (about the size of a pinhead) that it is often not noticed. Most commonly, the tick merely bites, draws blood for nourishment and then drops off. If the tick is infected with this bacteria, it may transmit them during the feeding process. ***It is important to note that a tick bite does not always result in Lyme disease.***

EARLY DISEASE SYMPTOMS: The typical early symptom of the disease is a slowly expanding red rash called *erythema migrans*. Only about ¾ of infected individuals will develop this rash. Anyone who has had a tick bite followed by a rash should consult a physician, as treatment at this stage is generally very effective. If left untreated, the rash will expand for several weeks and fade. Many times, no more symptoms occur.

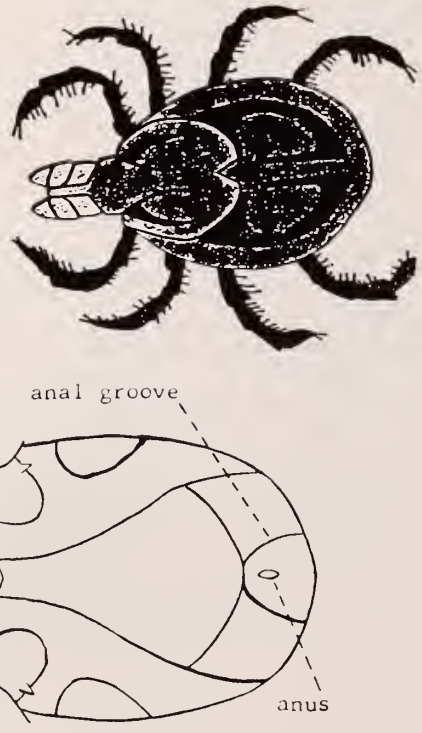
LATER DISEASE SYMPTOMS: Later symptoms of the untreated disease can include joint pain and complications involving the heart and nervous system. Most patients, if treated during the time of the rash, do not develop these later symptoms. Most commonly, the late symptoms include joint pain and swelling, and with such, termed Lyme arthritis. The pain usually occurs in a single joint, will go away after a few days, and then recur in another joint. The arthritis may occur from one to many months after the tick has transmitted the bacteria in its bite.

The disease is easily mistaken for other types of arthritis. Generally, there is no cartilage or bone damage noted. The disease can be treated effectively at this stage. The heart disease may occur within one to three weeks after the rash and may include symptoms such as dizziness, weakness, and irregular heart beat. Nervous system symptoms generally develop about 30 to 45 days after the rash first appears and may be characterized by intermittent headaches, difficulty concentrating, irritability, poor motor coordination, numbness, and pain. Some people develop weakness of the facial muscles. These symptoms, as well, can be treated.

TREATMENT: Most importantly, it should be noted that Lyme disease can be treated by antibiotics given either in an oral, intramuscular, or intravenous method. Penicillin, tetracycline, and erythromycin are all equally as effective.

The disease can be prevented by following these suggestions: (1) Avoid tall grasses, bushes, and woods; (2) Wear proper clothing—a hat, tucked-in shirt, long pants tucked into socks and good shoes; tick repellents may be helpful; (3) Monitor yourself and pets immediately from coming inside, inspecting clothing and undressing checking for ticks. Check your pets carefully; tick collars or powders may help to keep ticks off of them.

In general, it is not known whether other blood-sucking insects transmit the disease. There is no evidence that American dog ticks are a major carrier of the disease.■



Identification of the Ixodes tick: *The Ixodes tick is about the size of a pinhead and smaller than many common ticks. On the underneath side the major identifying factor is the anal groove extending as an inverted U from in front of the anus to posterior (hinder end) margins of the body.*

Magnetic resonance imaging

Since its clinical introduction in the early 1980s, magnetic resonance imaging (MRI) has had a major impact on the practice of neurology, proving superior to computed tomography (CT) for imaging many diseases of the brain and spine. In fact, a report by the AMA's Council on Scientific Affairs says that MRI has clearly replaced CT in some instances, and it is likely that it will replace myelography for assessing some spinal problems.—*AMA Briefs*■

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1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, LDH, SGDT, SGPT, and other phenomena consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Dermatological events (see ADVERSE REACTIONS section) may be transient and may disappear despite continued use of CARDIZEM. However, skin eruptions progressing to erythema multiforme and/or exfoliative dermatitis have also been infrequently reported. Should a dermatologic reaction persist, the drug should be discontinued.

Drug Interaction. Due to the potential for additive effects, caution and careful titration are warranted in patients receiving CARDIZEM concomitantly with any agents known to affect cardiac contractility and/or conduction. (See WARNINGS.)

Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

As with all drugs, care should be exercised when treating patients with multiple medications. CARDIZEM undergoes biotransformation by cytochrome P-450 mixed function oxidase. Coadministration of CARDIZEM with other agents which follow the same route of biotransformation may result in the competitive inhibition of metabolism. Dosages of similarly metabolized drugs, particularly those of low therapeutic ratio or in patients with renal and/or hepatic impairment, may require adjustment when starting or stopping concomitantly administered CARDIZEM to maintain optimum therapeutic blood levels.

Beta-blockers: Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities.

Administration of CARDIZEM (diltiazem hydrochloride) concomitantly with propranolol in five normal volunteers resulted in increased propranolol levels in all subjects and bioavailability of propranolol was increased approximately 50%. If combination therapy is initiated or withdrawn in conjunction with propranolol, an adjustment in the propranolol dose may be warranted. (See WARNINGS.)

Cimetidine: A study in six healthy volunteers has shown a significant increase in peak diltiazem plasma levels (58%) and area-under-the-curve (53%) after a one-week course of cimetidine at 1,200 mg per day and diltiazem 60 mg per day. Ranitidine produced smaller, nonsignificant increases. The effect may be mediated by cimetidine's known inhibition of hepatic cytochrome P-450, the enzyme system probably responsible for the first-pass metabolism of diltiazem. Patients currently receiving diltiazem therapy should be carefully monitored for a change in pharmacological effect when initiating and discontinuing therapy with cimetidine. An adjustment in the diltiazem dose may be warranted.

Digitalis: Administration of CARDIZEM with digoxin in 24 healthy male subjects increased plasma digoxin concentrations approximately 20%. Another investigator found no increase in digoxin levels in 12 patients with coronary artery disease. Since there have been conflicting results regarding the effect of digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing CARDIZEM therapy to avoid possible over- or under-digitalization. (See WARNINGS.)

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/ postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	Angina, arrhythmia, AV block (first degree), AV block (second or third degree—see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.
Nervous System:	Amnesia, depression, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.
Gastrointestinal:	Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGDT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.
Dermatologic:	Petechiae, pruritus, photosensitivity, urticaria.
Other:	Amblyopia, CPK elevation, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established. Issued 6/87

See complete Professional Use Information before prescribing

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Loss Prevention Corner

Physicians, their families, and stress

Michael C. Reineck, MD, West Bend

The tragic effect that a malpractice suit has on physicians and their families is an area of the medical liability crisis which has received little attention.[1] When served a summons, no matter how many times it has occurred in the past, all physicians suffer significant psychological stress.[2] This stress affects physicians immediately, especially in their patient care.[3] A physician, during the initial period of confusion and psychological readjustment, is more prone to commit malpractice through poor judgement calls. Physicians lose confidence in themselves and avoid further stress through patient referral or practice limitation.[4] There are no other professional stresses which can compare, or which can continually keep a physician on the defensive.[5]

As in their professional lives, physicians frequently fail to recognize the spill-over of stress into their families' lives. The stress from a malpractice suit increases and accentuates the stresses that are already occurring within the family.[6] Stress on the family from a malpractice suit is superseded only by stress caused by death, illness, or separation of a family member.

Sara Charles, MD, has documented radical changes in physicians' pre- and post-suit attitudes.[7] Dr Charles describes these symptom clusters as a major depressive disorder or adjustment disorder. Dr Charles suffered many of these same symptoms and illustrates them in the autobiographical account of her suit.[2]

To understand the depths to which a physician is affected, an understanding of the physician's compulsive nature is needed.[8] During their training, physicians are ingrained with the need to protect and preserve the patient's life at all costs. They are often instructed, "Above all do no harm" in selecting a treatment program for the patient. Physicians perceive a malpractice action as a direct attack on them. A malpractice suit is a challenge to the physician's integrity. The suit, by its very nature, alleges that the physician's care was below the minimum standard and has resulted in harm to the patient. Physicians, not unexpectedly, take the allegation personally and respond in a defensive manner. Initially physicians are in a state of shock and disbelief.[9] Denial is common, and many physicians ignore the summons until forced to respond.[10] The initial phase of shock is replaced with a deep feeling of hurt and shame. This phase slowly evolves into the phase of anger. As physicians come to grips with their emotions, they pass into the phase of accepting the situation and begin working the problem out.

The complex and extensive effects of a suit on the family are poorly understood and greatly underestimated by most physicians.[11] Mistakenly, many physicians fail to discuss the suit with their families in an attempt to protect them from the stress. Secrecy, rather than helping, actually compounds stress when family members sense there is a problem but do not know what it is.

An uninformed spouse, aware there has been a dramatic change in the physician's personality, may misinterpret this change, possibly feeling that the physician no longer cares for the spouse. Communication helps the physician handle the stress and provides the spouse with insight into the physician's mood changes. Through discussion, spouses can deal with their stress. Not surprisingly, the spouses' stress factors are very similar to those of the physicians':

- sense of deep loss;
- feeling of marital isolation;
- fear of financial vulnerability;
- social awkwardness;
- feeling of social isolation; and
- need to provide support for the family, especially the children.

At an appropriate time, the children should be informed and educated about the suit. As the suit becomes public knowledge, there will be a dramatic change in the children's relationship with their peers. The worst place the children can learn of a suit is from friends whose sources of information are possibly sensationalized stories on TV or radio, in newspapers, or hearsay. It is important that the children understand they are not the cause of the changes occurring within the phy-

Dr Reineck is a member of the SMS Medical Liability Committee and Risk Management Subcommittee. The *Wisconsin Medical Journal* thanks the American Academy of Orthopedic Surgery for permission to publish this article. Questions regarding the SMS Physician Support Group should be directed to Kit Nimtz, SMS Division of Medical Policy and Practice.

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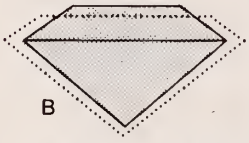

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sician—especially the physician's anger. Children must be given the tools to handle the possible taunting and questions from their peers who will have only incomplete information.

Children's stress factors are (these will vary with age and personality): need for reassurance; need for verbalization at their level; loss of family mores—behavioral changes need to be monitored.

Reading about malpractice can provide physicians and their families with a foundation to cope with stress. Talking it out will help physician and spouse even more. To facilitate this exchange, a support group of physicians and spouses has been formed. The support program contacts physicians and their spouses shortly after the allegation is filed for mediation. The contact letters include a description of the program and a list of support group members. Physicians may choose to contact anyone they wish from the list. Separate letters to spouses are sent a week later, advising them of the availability of a support group.

In conclusion, I offer these suggestions to reduce the stress of a suit.

• Be aware of the common and avoidable mistakes that you might make during the initial shock and disbelief stages of a malpractice suit. We will list the ten most common errors which may hurt your case in the next Loss Prevention Corner.

• The day you receive the summons notify your medical malpractice insurance company. Follow the advice of your insurance company and your defense counsel.

• Discuss early with your spouse your feelings about the suit. This discussion will help both of you deal with the stress. If you desire additional assistance, contact a member of the Physicians' Support Group.

• When appropriate, inform your children of the suit. Tell them enough to help them deal with their own stress and offer as much counseling as they will accept.

• Be gentle on yourself. We often are our own worst critics holding ourselves to standards even Hippocrates could not achieve.

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PIC-Wisconsin reports strong first year

Physicians Insurance Company of Wisconsin, formed in late 1986 to provide medical professional liability insurance to the state's physicians, reported premiums earned of $4.5 million and net income of $243,329—or $28.74 per share—for the year ended Dec 31, 1987.

The new insurer completed its first year with loss reserves of $3.6 million, shareholders' equity (capital and surplus) of $6.6 million, and total assets of $15.6 million.

Owned principally by physician-shareholders and the State Medical Society of Wisconsin, Physicians Insurance Company of Wisconsin presently insures more than 2,600 solo practitioners and staff members

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of large clinics, representing approximately 40% of the market.

Richard W. Edwards, MD, Richland Center, is chairman of the Board of Directors, and Jerome W. Fons, Jr, MD, Cudahy, serves as president of the company. William T. Montei, executive vice president, heads a professional insurance management team provided by Physicians Insurance Company of Ohio, a well-established medical professional liability insurer that provides management services and maintains a minority-ownership position in medical professional liability insurance companies in four other states.

Dr Edwards stated: "We are pleased with the progress of our company during its first year. While emphasizing conservative loss-reserving philosophies, our company recorded an operating profit that will enhance the financial stability of Physicians Insurance Company of Wisconsin. Our goal in 1988 is to continue recording financial progress as we expand our policyholder base."■

Medicare: questions and answers

The SMS Division of Medical Policy and Practice receives phone calls each day on a number of Medicare issues. We would like to share with you the most commonly asked questions so all physician offices can benefit from our answers.

Q. Is it possible for the 1987 MAAC on my Provider Pricing Profile to be different from the 1987 MAAC I received at the beginning of 1987?

A. Yes, it is possible for your 1987 MAAC found in the Prior MAAC column of your profile to be different from the 1987 MAAC received last year. If WPS-Medicare re-evaluated charge data for a particular procedure code and changes were made, it will affect the Area Prevailing charge data, which may change your 1987 MAAC. The Prior MAAC is the most current and should be used in any further calculations.

Q. The county listed on my 1988 Provider Pricing Profile is incorrect. What should I do?

A. There are a number of counties found in each locality. When WPS-Medicare printed the profiles, the first county on the listing printed on the profile. If your locality is correct, you should have correct profile data. Listed below are the counties found in each locality.

Loc 4
01 Milwaukee
02 Milwaukee
73 Milwaukee

Loc 12
04 Ashland
05 Barron
06 Bayfield
09 Burnett
12 Clark
18 Douglas
28 Iron
49 Polk
51 Price
55 Rusk
58 Sawyer
61 Taylor
66 Washburn

Loc 13
03 Adams
13 Columbia
26 Green Lake
31 Juneau
41 Marquette
42 Monroe
70 Waushara

Loc 14
14 Crawford
24 Grant
27 Iowa
35 Lafayette
53 Richland
57 Sauk
63 Vernon

Loc 15
15 Dane
74 Dane

Loc 19
08 Buffalo
11 Chippewa
19 Dunn
20 Eau Claire
29 Jackson
34 La Crosse
47 Pepin
48 Pierce
56 St. Croix
62 Trempealeau

Loc 36
36 Langlade
37 Lincoln
39 Marathon
44 Oneida
50 Portage
64 Vilas
72 Wood

Loc 40
07 Brown
17 Door
21 Florence
23 Forest
33 Kewaunee
40 Marinette
43 Oconto
45 Outagamie
59 Shawano
69 Waupaca

Loc 46
32 Kenosha
46 Ozaukee
52 Racine
67 Washington
68 Waukesha

Loc 54
16 Dodge
25 Green
30 Jefferson
54 Rock
65 Walworth

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Loc 60

10 Calumet
22 Fond du Lac
38 Manitowoc
60 Sheboygan
71 Winnebago

Q. If a procedure code doesn't appear on my Provider Pricing Profile, how do I know what my reimbursement will be?

A. If a procedure code doesn't appear on your Provider Pricing Profile, it means the service wasn't billed a minimum of three times between July 1, 1986, and June 30, 1987, to establish a customary charge. In this case, Medicare pays the lowest of:

1. the 50th Percentile,
2. the Adjusted Prevailing Charge,
3. the physicians actual charge.

This information is found on the Area Prevailing Profile. This profile can be ordered through WPS-Medicare. There is a charge for the material.

Q. How do I know if the Special Charge Limit applies to my services?

A. The Special Charge Limit applies to all procedure codes in which an R is found in the PI Column of your Provider Pricing Profile.

Q. Are clinical lab tests subject to a MAAC?

A. Clinical labs are considered a nonphysician service, and therefore are not subject to a MAAC.

Q. When completing the $500 elective surgery form, how do I know how much Medicare will allow?

A. Medicare approves the lowest of:

1. the customary charge (if you don't have a customary charge for a service use the 50th Percentile in its place),
2. the Adjusted Prevailing Charge,
3. the actual charge for the service.

The Customary and Adjusted Prevailing figures may be found on your Provider Pricing Profile. If a procedure code isn't listed on this profile, use the Area Prevailing Profile to determine the lower of the 50th Percentile and Adjusted Prevailing.

Q. What surgeries are considered elective by Medicare?

A. Elective surgery for Medicare is defined as surgery that can be scheduled in advance, is not an emergency and, if delayed, would not result in death or permanent impairment.

Q. Do I need to update signature-on-file cards each year?

A. No. The signature-on-file cards only need to be signed once.

If you have questions about Medicare that you would like to see answered in this column, send them to: Medicare Q&A, c/o Karen Lord, State Medical Society of Wisconsin, PO Box 1109, Madison, WI 53701.■

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WHAT'S THE REAL "BOTTOM LINE?"

When health care leaders get together these days, the terminology seems considerably different than not so long ago. Without question, business terms have their place in health care today –terms like "trend correlation... segmentation... **bottom line.**"

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New AIDS model proposed at SMS conference

Participants in a recent SMS conference on AIDS heard an eminent California researcher propose a revolutionary new model for the pathogenesis of HIV, in which the immune system is overstimulated and burns itself out. The conference, which was cosponsored by the Wisconsin Hospital Association, was held April 8 at the MECCA in Milwaukee and attended by about 250 physicians and other health care professionals.

Michael S. Ascher, MD, deputy chief of the California Viral and Rickettsial Disease Laboratory, told the audience that according to his model, the HIV virus does not directly suppress the immune system by killing T-cells as is currently believed, but instead acts indirectly by bonding to T-cells and continually telling them to turn on. Dr Ascher compared the situation to a man on a treadmill who is running as fast as he can being told to run even faster; the man, if he is unable to stop and rest, will collapse, which is what happens to the immune system.

According to Dr Ascher's theory, treatments that attempt to boost an AIDS patient's immune system are "like throwing fuel on the fire." Instead, he said, researchers should find ways of blocking the binding of HIV to T-cells or of killing the affected cells.

Dr Ascher said he began to question conventional wisdom on HIV because AIDS victims exhibit symptoms, such as fever and wasting, of an overactive immune system, because the incubation period of five years does not fit the pathogenesis of a disease that attacks cells directly, and because only one in 10,000 T-cells is found to be infected with HIV.

His findings will be published later this year in an English medical journal.

Left to right: Mr Harold Brown, administrator of the Prairie du Chien Memorial Hospital; Jerome H. Gundersen, MD, chairman of the Governor's Advisory Council on AIDS; Michael Dailey, MD, member of the SMS AIDS Task Force; Donald P. Francis, MD, CDC AIDS advisor to the State of California; and (standing) Cyril M. Hetsko, MD, chairman of the SMS AIDS Task Force.

Conference participants also heard a moving call to action from Donald P. Francis, MD, AIDS advisor to the State of California for the Centers for Disease Control, who spoke to the group about public health issues. Dr Francis began his talk with an emotional plea for understanding and compassion for homosexuals. "This is a part of the population with a wealth of skills and abilities, and we don't want to lose them," he said.

According to Dr Francis, society has two obligations regarding AIDS: to take care in a humane way of the large numbers of people already infected and to prevent noninfected groups from getting sick. What is needed, according to Dr Francis, is a "maximally effective, yet minimally disruptive" program to prevent the spread of AIDS.

Dr Francis predicted that "family AIDS" would be the "AIDS of the future." It will be a "smoldering, miserable outbreak," he said, mainly affecting minorities, the poor and IV drug abusers. To stop the spread of AIDS, physicians and other health professionals must help people change their behavior regarding sexual activity and IV drug use, help foster an atmosphere of trust and cooperation so people will want to be tested for AIDS, and work together through medical societies and other groups to help educate state and federal policy makers.

Other speakers at the day-long conference were: Jean Pierre Allain, MD, manager of medical research for Abbott Laboratories; Jeffrey P. Davis, state epidemiologist and chief of the Acute and Communicable Disease Epidemiology Section in the Department of Health and Social Services; Paul A. Turner, MD, clinical instructor in the Division of Infectious Diseases at the Medical College of Wisconsin; and Michael W. Rytel, MD, professor of medicine and section chief of the Division of Infectious Diseases at MCW. Presentations covered a wide spectrum of AIDS-HIV topics including the epidemiologic history of the epidemic, infection data from Wisconsin, testing accuracy and new tests for HIV, prognostic factors and monitoring of the infection, treatment approaches, and the neuropsychiatric aspects of AIDS.

The program also featured a discussion on public health issues in Wisconsin by a reactor panel of representatives from the Wisconsin Hospital Association, Governor's Advisory Council on AIDS and the State Medical Society of Wisconsin.■

COUNTY SOCIETIES

*Physician members of the State Medical Society of Wisconsin

FOND DU LAC: Members of the Fond du Lac County Medical Society, at their February meeting, heard Darold A. Treffert, MD,* Fond du Lac, speak on "Medical Marriages." At the business session of the meeting, it was voted to send a stipend of $1,000 to the Museum of Medical Progress in Prairie du Chien and also for the county medical society to support the city's fluoridation policy.

OUTAGAMIE: Members and guests of the Outagamie County Medical Society heard Thomas Hefty, Milwaukee, president of Blue Cross/Blue Shield Insurance Company of Milwaukee, speak on the "Present Status of Health Insurance in Wisconsin." Michael W. Milde, MD,* Menasha, was accepted to membership of the Society.

WINNEBAGO: Susan Talbot-Stanaway, curator of education at the Paine Art Center in Menasha, was the guest speaker at the March meeting of the Winnebago County Medical Society. Her topic was entitled "What's American about American Art."

WOOD: Twenty-nine members were present at the March meeting of the Wood County Medical Society. Also present were Paul Markowski, assistant manager, Medical Society Relations of the State Medical Society, who answered questions on the State Budget of Wisconsin, and Gerald C. Kempthorne, MD,* Spring Green, who spoke on the Impaired Physicians Program. Thomas A. Ho, MD,* Wisconsin Rapids, was appointed as a member to the Young Physicians Section, and Dr Jung K. Park's* resignation from the SMS Board of Directors was announced.■

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The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin recognizes the generosity of the following individuals and organizations who have made contributions during the month of February 1988.

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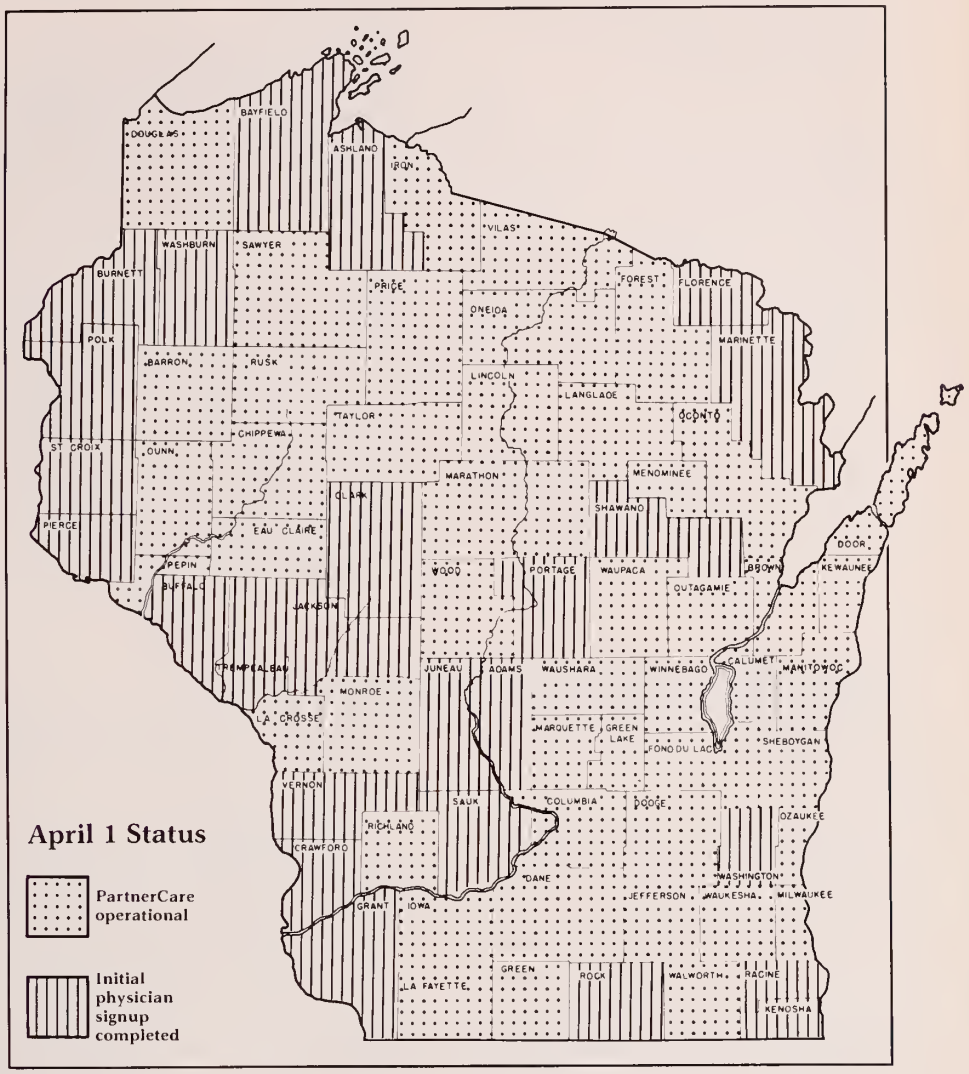
PartnerCare participation covers the state

Nearly 5,000 physicians across the state have agreed to participate in PartnerCare, and initial physician sign-up is now complete. As of April 1, PartnerCare was fully operational in 45 counties.

A joint effort by the SMS, the Coalition of Wisconsin Aging Groups and local aging offices, PartnerCare is a voluntary Medicare assignment program for low-income elderly citizens.

During the past year, physicians have been asked to take part in the program by accepting the Medicare-allowed amount as payment in full for services provided to PartnerCare enrollees. Physician response has been "heartening" according to Kenneth M. Viste, Jr, MD, president of the SMS. "Through their participation in PartnerCare, physicians are continuing to demonstrate their concern for Wisconsin's low-income elderly," he said. According to Tom Adams, secretary-general manager of SMS, solicitation postcards from physicians continue to arrive daily at SMS headquarters.

At a news conference held recently to announce the launching of the program in Marathon, Langlade and Wood counties, Rep David Obey (D-Wis) praised SMS as "one of the most progressive state medical societies in the nation" for its role in PartnerCare.■



*Physician members of the State Medical Society of Wisconsin

NEWS HIGHLIGHTS

The Marshfield medical complex, which includes Saint Joseph's Hospital, Marshfield Clinic and the Marshfield Medical Research Foundation, later this year will join the growing number of healthcare institutions around the state that have become smoke free. The new policy results from a survey last year of employees, patients, clergy, physicians, students, visitors, and volunteers in which 70% of the respondents said they favored a smoke-free medical complex.

Ripon Memorial Hospital's medical staff recently elected Robert H. House, MD,* chief of staff and David B. Rich, MD,* vice chief. Teodoro M. Ramos, MD,* was reelected secretary.

St. Michael's Hospital in Stevens Point recently announced that Joseph F. Farabek, MD, has been elected president of the medical staff. Other officers include Steven C. Bergin, MD,* vice president, John P. Gauder, MD, secretary-treasurer. All three physicians are affiliated with Rice Clinic.

The Plainfield Clinic, which had been closed for several years, recently reopened staffed by three physicians from the Wild Rose Waushara Doctors Clinics. The three are Roger A. Kjentvet, MD,* Rodney D. Wichmann, MD,* and T.P. Romana, Jr, MD.

The medical staff of Memorial Hospital of Taylor County recently voted

in a new slate of officers. They are: Michael A. Haase, MD,* chief of staff; LeRoy A. Krueger, MD,* vice chief of staff; and Romulo P. Moscoso, MD,* secretary.

Howard Young Health Care, Inc, president George T. Anast, MD, recently announced that Jerry Burdick has been named vice president of marketing and development. Mr. Burdick previously served as special assistant to the president of Howard Young Health Care and before that was chief executive officer of Eagle River Memorial Hospital.

Robert E. Johnston, MD,* recently was named president of West Side Clinic of Green Bay. Other physicians appointed as officers at the clinic are: Ronald G. Thune, MD,* vice president; David L. Samuel, MD,* secretary; and Jay J. Tibbetts, MD,* treasurer.

Physicians at St. Clare Hospital in Monroe recently elected the following physicians as officers: Jan E. Erlandson, MD,* president; Carleton Davis, MD, president elect; and Bharathy E. Nair, MD,* treasurer.

Harold B. Goebel has been appointed associate administrator and chief operating officer of the Racine Medical Clinic. Mr Goebel has a master's degree in Hospital and Health Administration from the University of Iowa, and prior to joining the Racine Medical Clinic, had been administrator of Perry Memorial Hospital in Princeton, Ill, Children's Hospital, Milwaukee, and vice president of MML Health Services, Inc in Milwaukee.

Marshfield Clinic's medical staff has reelected Sidney E. Johnson, MD,* to a third consecutive term as president of the Clinic. Dr Johnson, a gastroenterologist, also served as the clinic's medical director for nine years. He graduated from the University of Wisconsin School of Medicine, Madison, and joined the Clinic in 1966. Joining Dr Johnson on the clinic's executive committee are MDs Richard A. Leer,* vice president; Susan L. Turner,* corporate secretary; and Paul L. Liss,* treasurer.

Neal Neuberger, a former staff member of the State Medical Society, has left Rep David Obey's staff to become a lobbyist for the American Hospital Association in Washington, DC.■

PHYSICIAN BRIEFS

*Physician members of the State Medical Society of Wisconsin

Gary Pesicka, MD, and **Roger W. Park, MD,** recently joined Marshfield Clinic. Dr Pesicka, an ophthalmologist, was formerly with the University of Texas Health Science Center in Dallas. He graduated from Washington University Medical School in St. Louis and completed his residency at the University of Texas Health Science Center. Dr Park previously was on the staff of Wichita Clinic in Wichita, Kansas, and was a clinical assistant professor at the University of Kansas School of Medicine. He graduated from the University of Kansas and specializes in gastroenterology.

Milton J. McMillen, MD, of La Crosse was recently named chairman of the Advanced Cardiac Life Support Subcommittee of the Wisconsin Chapter of the American Heart Association. Dr McMillen is a physician in the Emergency Medical and Trauma Center at St. Francis Medical Center and director of the center's advanced cardiac life support courses.

Michael P. Mehr, MD,* of Marshfield and Susan F. Behrens, MD,* of Beloit have been appointed to the State Medical Examining Board. Both physicians are active in SMS affairs. Dr Mehr has served on the WISPAC Board, the Physicians Alliance Commission and the WNA-SMS Liaison Committee. Dr Behrens, who previously served on the Medical Examining Board and was its chairman from 1984 to 1986, received the SMS Civic Leadership Award in 1986. She also served on the SMS Task Force on Physician Review and Discipline. Both terms are for four years and are effective May 1.

Michael J. Black, MD,* and **John J. Downing, MD,*** both of Janesville, recently joined Memorial Community Hospital in Edgerton. Both physicians are ophthalmologists on staff at Riverview Clinic in Janesville.

David J. Clardy, MD, recently joined the medical staff of the Milwaukee Medical Clinic at the Port Washington Center and the Cedar Creek Center in Grafton. Dr Clardy graduated from Washington University in St. Louis and completed his internship and residency at Michael Reese Hospital and Medical Center in Chicago. He is board certified in internal medicine and internal medicine cardiovascular disease.

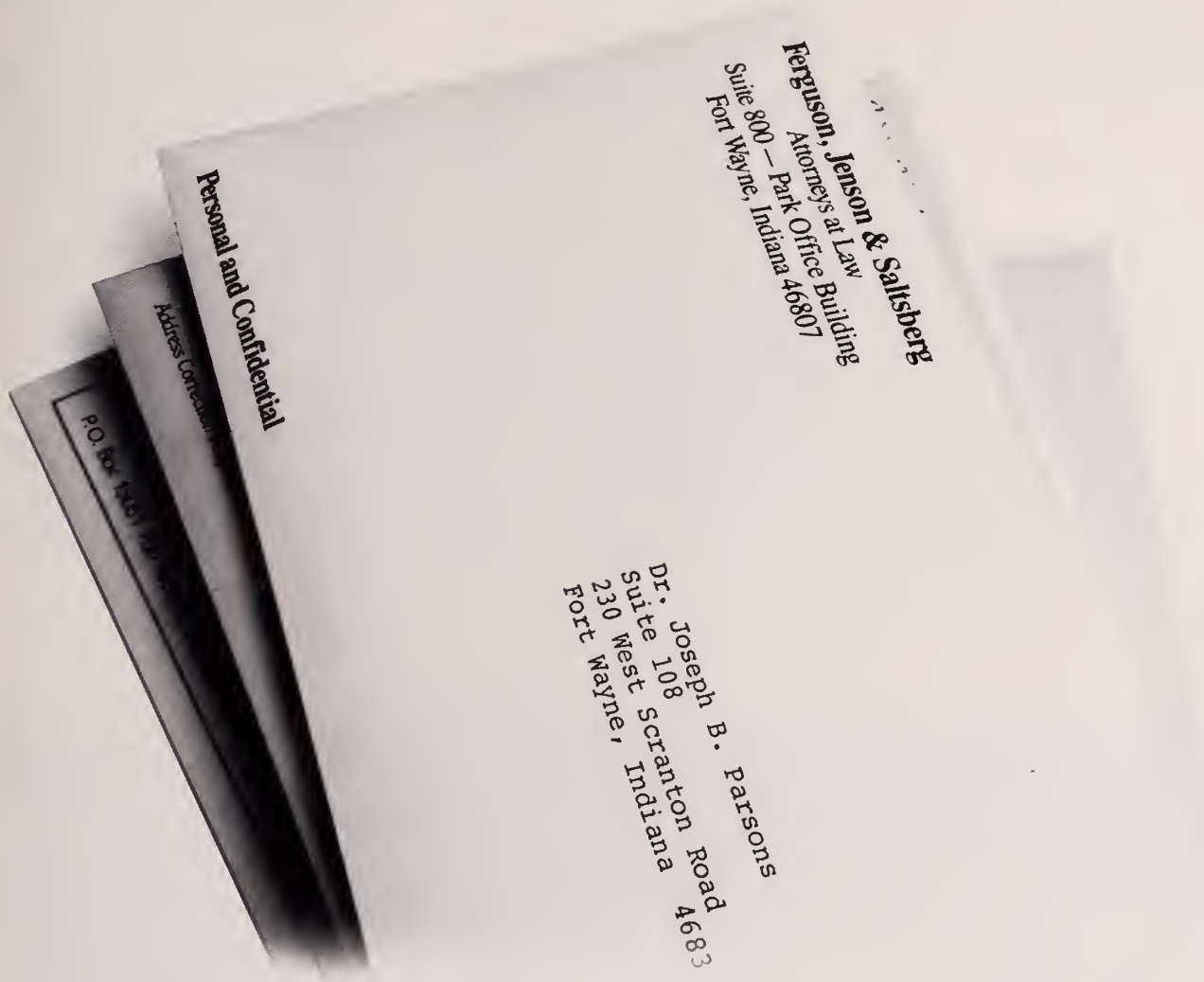
James W. Koch, MD,* of Colby recently retired after 36 years in practice. Dr Koch graduated from the University of Wisconsin.

Jeanna L. Owens, MD,* of Oshkosh recently joined the medical staff at St. Agnes Hospital in Fond du Lac. Dr Owens graduated from the Medical College of Georgia and served her residency at the McGaw Medical Center of Northwestern University in Chicago. She also completed a three-year fellowship in rheumatology at the Medical College of Wisconsin.

Joshua Sun, MD,* of Eau Claire recently joined the medical staff of Sacred Heart Hospital. A pediatrician, Dr Sun received his medical degree from Taiwan University School of Medicine and completed his residency at the New Jersey Medical

continued on page 46

Crisis in black and white.



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continued from page 44

Center in Newark. He also completed a fellowship at the University of Saskatchewan. Before joining Sacred Heart, Dr Sun was on staff at St. Gabriel's Hospital and Little Falls Clinic in Little Falls, Minn.

James R. Damos, MD,* of Oregon recently joined the Verona Family Practice Clinic, Verona, as associate director of the residents training program. Dr Ramos attended St. Louis University Medical School and completed an internship and residency in family practice at Edward W. Sparrow Hospital in Lansing, Michigan.

Archie G. Britt, MD,* of La Crosse recently joined Skemp Clinic. He is a Board-certified general surgeon. Dr Britt graduated from the University of Wisconsin–Madison and completed his residency at University Hospital and Case Western Reserve University in Cleveland.

Frederick L. Whitlark, MD,* recently retired from medical practice. He had been on the staff of the Family Medical Clinic in Amery and had practiced in the area for 39 years.

Frank J. Pulito, MD,* of Milwaukee has joined Countryside Home in Jefferson as staff physician. He has been staff physician for the Milwaukee County Mental Health Complex and Southern Wisconsin Center in Union Grove. Dr Pulito is a fellow of the American Geriatric Society and the American Academy of Family Physicians. He is also past president of the Milwaukee Neuropsychiatric Society and a recipient of the AMA Physicians Recognition Award.

Raymond C. Zastrow, MD,* of Wauwatosa was recently appointed secretary-treasurer of the College of American Pathologists by the board of governors. Dr Zastrow is associate pathologist and director of hematology and radiochemistry at St. Michael Hospital in Milwaukee. He is also associate clinical professor of pathology at the Medical College of Wisconsin.

Nicholas S. Omdahl, MD,* of Racine recently joined St. Marys Medical Center. He graduated from the University of Wisconsin–Madison and served his internship and residency at William Beaumont Army Medical Center in Texas.■

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Clement L. Lacke, MD
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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

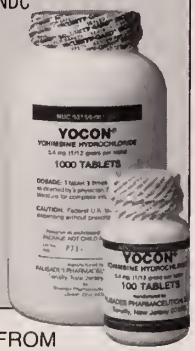
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



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4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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BRIEF SUMMARY

CONTRAINDICATIONS

There are no known contraindications to the use of sucralfate

PRECAUTIONS

Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that simultaneous administration of CARAFATE (sucralfate) with tetracycline, phenytoin, digoxin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The clinical significance of these animal studies is yet to be defined. However, because of the potential of CARAFATE to alter the absorption of some drugs from the gastrointestinal tract, the separate administration of CARAFATE from that of other agents should be considered when alterations in bioavailability are felt to be critical for concomitantly administered drugs.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). There was no evidence of drug-related tumorigenicity. A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies were not conducted.

Pregnancy: Teratogenic effects. Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%).

Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

OVERDOSAGE

There is no experience in humans with overdosage. Acute oral toxicity studies in animals, however, using doses up to 12 gm/kg body weight, could not find a lethal dose. Risks associated with overdosage should, therefore, be minimal.

DOSAGE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

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Issued 1/87

References:

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4. Marks IN, Wright JP, Gilinsky NH, et al. *J Clin Gastroenterol* 8:419-423, 1986.
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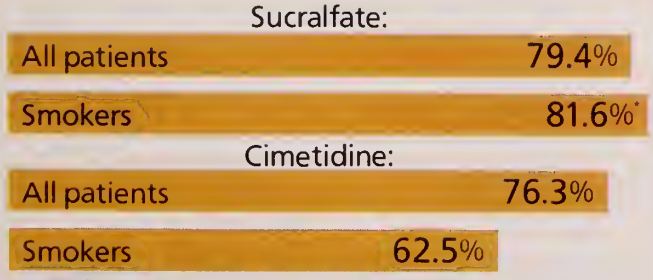

*Significantly greater than cimetidine smoker group ($P < .05$)

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Please see adjoining page for references and brief summary of prescribing information.

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Soldier being examined for effects of high-altitude cerebral edema.

ALLAN J. HAMILTON, M.D.

Neurosurgical Resident and Research Fellow, Massachusetts General Hospital, Boston, Massachusetts. Captain, U.S. Army Reserve.

EDUCATION Ithaca College, B.A. (Magna Cum Laude); Hamilton College (Pre-med); Harvard Medical School.

RESIDENCY General Surgical Internship. Neurosurgical Residency, Massachusetts General Hospital.

CONTINUING EDUCATION Neurology and Neurosurgery Research Fellowship Training, National Institutes of Health.

OUTSTANDING ACHIEVEMENTS Olsen Memorial Fellowship, National Masonic Medical Research Foundation; Albert Schweitzer Fellowship, International Albert Schweitzer Foundation; Harvard Medical School Cabot Prize for Best Senior Thesis; recently published article, "Who Shall Live and Who Shall Die" in Newsweek Magazine.

"The work I'm doing in the Army Reserve fits perfectly with my academic research interests in civilian life. The Army is very concerned with the effects of high-altitude cerebral edema, which is a mirror model of cerebral hypoxia, something I deal with every day in our neurosurgical intensive care unit. I couldn't ask for a smoother transition. And that's true for a lot of Reserve physicians. All we really do is change our clothes, not our mindset.

"Some of the projects the Army is undertaking are on the cutting edge of research. For example, I'm currently involved in developing for the Army a prototype of a non-invasive intracranial pressure-monitoring device that we hope will allow us to measure pressure changes as the brain swells—without drilling holes in the skull. If we can get our design to work, such a device could revolutionize high-altitude medicine as well as civilian neurosurgical care.

"The quality of medicine and the caliber of people I've been associated with in the Army Reserve are, without question, equal to civilian hospitals. In fact, I'm giving serious consideration to applying for an active duty academic position in Army Medicine when my residency ends at Massachusetts General."

Find out more about the medical opportunities in the Army Reserve. Call toll free 1-800-USA-ARMY.

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BLUE BOOK/UPDATE

On page 168 of the June 1987 BLUE BOOK issue, the following changes have been made under the SMS Committee on Aging, Extended Care Facilities and Home Health Care. Sailendra Nath Basu, MD, Wausau, and Sharon L. Maby, MD, Marshfield, have resigned.

On page 170 under the WNA-SMS Liaison Committee, Michael P. Mehr, MD, Marshfield, has resigned.

On page 176 of the June BLUE BOOK issue, the following changes have been made under the Presidents and Secretaries, Wisconsin Specialty Societies.

Orthopaedics

(April 1990)
P—Michael C. Reineck, MD
1201 Oak Street
West Bend, WI 53095.

On page 174 under the Section on Orthopaedics the following changes should be made:

(April 1990)
C—Michael C. Reineck, MD
1201 Oak Street
West Bend, WI 53095
D—David D. Mellencamp, MD
3970 North Oakland Ave., #501
Milwaukee, WI 53211
AD—James Langenkamp, MD
2040 West Wisconsin Avenue
Milwaukee, WI 53233.■

OBITUARIES

John Joseph Colgan, MD, 87, Eagle River physician for 57 years, died Feb 28, 1988, in Eagle River. Born in Wichita, Kansas, Dr Colgan graduated from Marquette University School of Medicine in 1929 and served an internship at St Joseph's Hospital in Milwaukee. His residency was completed at Milwaukee County General Hospital. He served in the US Army during World War II as a medical officer in the 3rd Army. Dr Colgan was a member of the Oneida-Vilas County Medical Society, State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Irene, and one son, Timothy K. Colgan, MD, of Beaumont, Tex.

Donald J. Gallagher, MD, 61, Green Bay, died Feb 15, 1988, in Green Bay. Born Oct 22, 1926, in Green Bay, Dr Gallagher graduated from the University of Wisconsin Medical School, Madison, served an internship at St Mary's Hospital, Duluth, Minn, and a residency in obstetrics/gynecology at Milwaukee County General Hospital. Dr Gallagher served in the US Army Air Force during World War II. He was a fellow of the American College of Obstetrics and Gynecol-

AMA Physician's Recognition Award Recipients

LISTED BELOW are those physicians in Wisconsin who have earned the AMA Physician's Recognition Award in recent months. The State Medical Society of Wisconsin congratulates these physicians who have distinguished themselves and their profession by their commitment to continuing education:

MARCH 1988

*Behling, Ronald E., Madison
*Boedecker, Robert A., Brookfield
*Bollow, Frederic W., Marshfield
*Borman, Richard J., Milwaukee
*Budzak, Kathryn S., Madison
Chang, Chen-Kang, Madison
Cusick, Joseph F., Milwaukee
*Denny, Arlen D., Milwaukee
*Dibbell, David G., Madison
*Doehlert, Charles A., Madison
Duffy, Thomas M., Kenosha
*Elias, Sharon L., Milwaukee
Estlund, Gregory J., Baldwin
*Finch, David R., Appleton
*Gingrass, Ruedi P., Milwaukee
*Giray, Erol F., Milwaukee
*Gueldner, Terry L., Manitowoc
*Hartwick, John P., Wauwatosa
*Hasenyager, Carol A., Milwaukee
*Hathway, Stephen D., Green Bay
*Hogan, John P., Milwaukee
*Jacobi, Michael A., Manitowoc
Jefferson, James W., Madison
*Johnson, Roger P., Milwaukee
*Kagen, Allan E., Milwaukee
*Keller, Thomas A., Manitowoc
*Kim, Zaezeung, Racine
*Kloehn, Ralph A., Wauwatosa
*Koob, Lynn D., Rice Lake
*Korkos, George J., Milwaukee
Larson, Sanford J., Milwaukee
*Lauderdale, Barbara Lewis, Neenah
*Lyne, Benjamin W., Milwaukee
*Magnino, James J., Kenosha
*Meyer, Glenn A., Milwaukee
*Miller, Michael M., Eau Claire
*Nordby, Eugene J., Madison
*Nowinski, Donald M., Wausau
*Pohl, Alan L., Milwaukee
*Reddy, Vangala J., Neillsville
*Reinhard, Harold J., Green Bay
Sanfelippo, Michael, Milwaukee
*Sherkow, Larry H., Milwaukee
*Stevens, Michael L., Marshfield
*Tiu, Alfonso L., West Allis
*Todd, Paul C., Menomonee Falls
*Towne, Jonathon B., Milwaukee
*Udoff, Eric J., Milwaukee
Walsh, Patrick R., Milwaukee
*Webster, Stephen B., La Crosse
*Wedro, Benjamin C., La Crosse
*Weisenthal, Charles L., Milwaukee
*Wilkins, Terrence J., Milwaukee
*Willson, D. Maclean, Milwaukee
Wilson, Stuart Dickinson, Milwaukee
*Zarwell, David H., Milwaukee

*Members of SMS.■

ogy, a member of Brown County State Medical Society, State Medical Society of Wisconsin, and American Medical Association. Surviving are his widow, Mary Lou; four sons, Dr John, Dr Michael, Green Bay; Dr Thomas, Chicago, Ill, and Daniel; and two daughters, Eileen Burnett, Green Bay, and Kathleen Schlittler of Brodhead.

Orvin G. Glesne, MD, 80, former Beloit physician, died Feb 22, 1988, in Alexandria, Minn. Born Jan 11, 1908, in Elkader, Iowa, Dr Glesne graduated from the University of Iowa Medical School in 1933. He served in the US Army during World War II. After service he served an anesthesiology residency at the University of Iowa. Dr Glesne practiced in Beloit and retired in 1970 to Lakeview, Ark, before moving to Alexandria, in 1980. He was a member of the Rock County Medical Society, State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Eunice; a daughter, Martha Cussier, New York City; and a son, Robert E. Glesne, MD, of Alexandria, Minn.

Victor G. Benson, MD, 77, Palm Desert, Calif, died Mar 4, 1988, in Palm Desert. Born June 7, 1920, in Soldiers Grove, Wis, Dr Benson graduated from Marquette University School of Medicine and served his residency at Ohio State University. Dr Benson served in the United States Navy and retired as a Captain in 1972. He was a flight surgeon, a balloon pilot and was a pioneer in the Mercury Space Program.

Samuel J. Faber, MD, 84, Racine physician for 42 years, died Feb 6, 1988, in Los Angeles, Calif. He was born July 19, 1903, in New York, and graduated from Rush Medical College, Chicago, Ill, in 1926. He served an internship and residency at Michael Reese Hospital in Chicago. He had his medical practice in Racine until his retirement in 1971.

William J. Harrington, MD, 91, Appleton, died Feb 7, 1988, in Appleton. Born May 31, 1896, in Oshkosh, Dr Harrington graduated from the University of Texas College of Medicine and served an internship at Butterworth Hospital, Grand Rapids, Mich. Dr Harrington practiced medicine in Appleton until his retirement and also served in the US Navy during World War I.■

Thomas A. Leonard, MD, 91, Middleton, died Mar 27, 1988, in Madison. Born Dec 4, 1896, in Middletown, Ohio, Dr Leonard graduated from the University of Wisconsin Medical School in 1931. He served an internship at the University of Wisconsin Hospital and completed his residency in obstetrics and gynecology at St Mary's Hospital in Madison. Dr Leonard was a longtime teaching member of the clinical faculty at the University of Wisconsin and Center for Health Sciences and a member of the staff at Madison General Hospital for over 40 years. He was a founding member and former president of the Wisconsin Society of Obstetrics and Gynecology. He was particularly active as the founder and chairman, for 25 years, of the State of Wisconsin Maternal Mortality Survey and Study Committee, sponsored by the State Medical Society of Wisconsin. He was one of the founding members and organizers of the Wisconsin Association for Perinatal Care. The Wisconsin Association formed the basis for the Great Plains Organization and the National Perinatal Association. Dr Leonard served as consultant and program coordinator for the establishment of seven regional Perinatal Centers within the state for the diagnosis and treatment of high-risk expectant mothers and infants compromised at birth.

Thomas A. Leonard, MD

He was a member and organizer of the Wisconsin Association of Senior Physicians in 1980. Dr Leonard received many honors and awards—from the University of Vera Cruz (he spent 20 years teaching in Mexico each February or March), Distinguished Service Award from the State Medical Society, June 1977; recipient, First Callon-Leonard Award of the Wisconsin Association for Perinatal Care, 1975; the Manfred Swarsensky Humanitarian Service Award, December 1984; and Distinguished Service Award, University of Wisconsin Medical Alumni Association, September 1985. Dr Leonard served in World War I and World War II.

Dr Leonard also was the author of two volumes, *The Begetters and the Begotten*, and *Love Expandeth the Wall*. Until he became blind ten years ago, he spent his retirement years engaged in art work.

Surviving is his sister, Caroline Swaim of Middletown, Ohio. Dr Leonard's wife preceded him in death in November 1987. He was a member of the Dane County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.■

PHYSICIANS EXCHANGE

Family Practitioner. Family Practice physician wanted to be associated with branch clinic of a large multispecialty group. Opportunity for family practice in Prairie du Chien, Whitehall, Viroqua or Tomah, Wisconsin; West Union, Iowa. Physician would be associated with a multi-specialty group. Relief provided for vacations, meetings, etc. Educational opportunities through an excellent education program. Beautiful countryside, cultural and recreational facilities. Excellent fringe benefits. Salary commensurate with background and experience. Write or call Tim Skinner, MSEd, Family Practice Representative, Gundersen Clinic, Ltd, 1836 South Ave, La Crosse, WI 54601. Equal Opportunity Employer. 5/88

BC/BE General Surgeon. Outstanding opportunity for general surgeon to associate with two active internists in a friendly rural community in northeastern Wisconsin near Green Bay. New clinic attached to a 55-bed community hospital. Excellent long-term growth potential. Send CV to Artwich Clinic, Ltd, 815 South Main St, Oconto Falls, WI 54154. p5-6/88

Family Medicine. Outstanding, diversified Family Practice opportunity in attractive riverfront community offering the support and resources of a major group with the autonomy of private practice. Competitive salary with productivity bonus and extensive benefits package along with paid interview and relocation expenses. Call Robert A. Douglas, MD, 1-800-327-1585. 5/88

Minneapolis. BC/BE Occupational Medicine specialist needed to join four person Occupational Medicine Department of a 280-physician multispecialty medical clinic in desirable Twin Cities area. Our medical clinic is a highly reputable, well-established clinic that has been in existence for over 37 years. Salary and benefits are highly competitive. Send CV and letter of inquiry to Jack Dunne, MD, Park Nicollet Medical Center, 5000 West 39th St, Minneapolis, MN 55416. p5/88

RATES: 50¢ per word, with a minimum charge of $20.00 per ad. BOXED AD RATES: $25.00 per column inch. *All ads must be prepaid.*

DEADLINE: Copy must be received by the 15th of the month preceding month of issue; *eg,* copy for the August issue is due July 15. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 1-800-362-9080.

Pediatrics. Marshfield Clinic. A 250-physician, multispecialty private group practice, is seeking a Board-certified or eligible general pediatrician to join its expanding regional center in Chippewa Falls. Chippewa Falls is a community of 15,000 people located in beautiful west central Wisconsin with a wide range of recreational, educational, and cultural opportunities easily accessible. The clinic is adjacent to a 110-bed JCAH accredited hospital. Competitive salary and fringe benefit package. Send curriculum vitae and references to Mr David Draves, Director, Regional Development, Marshfield Clinic, 1000 North Oak Ave, Marshfield, WI 54449. Or you may call collect at 715-387-5376. 5/88

Minneapolis. Urgent Care physicians (full-time), that are BC/BE in their specialty area, needed to join the Department of Urgent Care of a 280-physician multispecialty medical clinic in desirable Twin Cities area. Our medical clinic is a highly reputable, well-established clinic that has been in existence for over 37 years. Salary and benefits are highly competitive. Send CV and letter of inquiry to Patrick Moylan, Park Nicollet Medical Center, 5000 West 39th St, Minneapolis, MN 55416. p5/88

Unopposed practice opportunity for Nephrologist to associate with an ABIM internist. Excellent salary guaranteed with incentive formula, 800 hospital beds, midwestern city of 100,000. Send CV and inquiries to Dept 615 in care of the Journal. p5/88

Unopposed practice opportunity for Infectious Disease specialist to associate with an ABIM internist. Excellent salary guaranteed with incentive formula, 800 hospital beds, midwestern city of 100,000. Send CV and inquiries to Dept 614 in care of the Journal. p5/88

Public Health. Laboratory Director. The City of Milwaukee is seeking qualified applicants to be responsible for the operation and program direction of the Health Department's Bureau of Laboratories which include the Divisions of Bacteriology, Chemistry, and Virology. Position requires a Master's degree in Bacteriology, Chemistry, Virology, Microbiology, or closely related field and five years of significant supervisory, administrative and managerial experience in a broad service health-related laboratory. A PhD, DPH or MD and public health experience are desirable. The current salary range is $52,037 to $72,850 with excellent benefits. The City's pay-for-performance system rewards excellent performance. For further information contact Mr Neil Driesen, City Personnel Dept, 200 East Wells St, Room 706, Milwaukee, WI 53202; ph 414-278-3380. An Affirmative Action Employer. Women, minorities, and handicapped are encouraged to apply. 5/88

Wisconsin, Northeastern. BC/BE Family Practice physician to join our multispecialty growing clinic in Appleton, Wisconsin. OB is optional. Guaranteed salary during the first year and an excellent benefit package with paid malpractice. The geographic region served includes the Fox River Valley, which is located in northeastern Wisconsin, and is a moderately populous, semi-urban area which prides itself on a high quality of life. Numerous outdoor recreational opportunities are readily available while two major universities, several small colleges, and active civic organizations provide cultural and educational opportunities for physicians and their families. For more information, please send your curriculum vitae or call Mr Art Schuetze, Administrator, Medical Arts Clinic, 1501 S. Madison St, Appleton, WI 54915; ph 414-730-4425. 5-7/88

Neurosurgeon. A busy and varied neurosurgical practice can be anticipated with this 35-physician multispecialty group. Two hospitals in city of 35,000 are fully equipped for neurosurgery. Guarantee and excellent benefit package. Call or write George Ivekich, 250 Regency Court, Waukesha, WI 53186; 1-800-338-7107 or 414-785-6500 (collect). No costs or obligations involved. p5/88

Career opportunity for qualified Emergency Room physician. Our group covers two hospital emergency rooms and an active walk-in clinic in southeastern Wisconsin. Full fringe benefit package and flexible scheduling offered. Interested parties contact John W. Linstroth, MD, 1201 Sherwood Lane, Caledonia, WI 53108; ph 414-835-7761. 5/88

Unopposed Rheumatologist, BC/BE to join ABIM internist in expanding practice, competitive salary guaranteed with incentive formula. Midwest. Start July 1988 or earlier. Send CV and inquiries to Dept 617 in care of the Journal. p5/88

Excellent practice opportunity for Internist, BC/BE to associate with an ABIM internist. Competitive salary guaranteed with incentive formula, 800 hospital beds, midwestern city of 100,000. Send CV and inquiries to Dept 616 in care of the Journal. p5/88

Family Practitioner to associate with a highly successful two physician (one physician near retirement) rural family health center with an excellent support staff and unlimited potential. Complete fee-for-service practice with excellent hospitals and specialty support only minutes away. Guaranteed salary, incentives and benefits tailored to fit your needs. Located 15 minutes from a major metropolitan area and 30 minutes from the joys of Door County. Interested physicians please contact J C Majeski, Clinic Mgr, Luxemburg Medical Clinic, PO Box C, Luxenburg, WI 54217; ph 414/845-2351. p3-5/88

PHYSICIANS EXCHANGE

continued

Family Practice Physicians to join Dean Medical Center. Attractive practice opportunity in multispecialty clinic in and around Madison, Wisconsin. Guaranteed salary, profit sharing, excellent fringes, and stockholdership. Send CV to Louis C. Bernhardt, MD, Chairman, Recruiting Committee, Dean Medical Center, 1313 Fish Hatchery Rd, Madison, WI 53715. Equal Opportunity/Affirmative Action Employer. 5-6/88

Primary Care. Primary care physician to work in "Walk-In" Department of 24-physician multispecialty clinic. 12 to 15 hours per week. Excellent back-up services. Complete lab and x-ray on-site. Lodging accommodations available. Contact: Administrator, Rice Clinic, 2501 Main St, Stevens Point, WI 54481 or call collect 715/344-4120. 6tfn/87

West Bend, Wisconsin, General Clinic, a 20-physician multispecialty group is seeking additional B/C, B/E physicians in **Family Practice, Pediatrics, OB/GYN, Internal Medicine, Urology, Dermatology,** and **ENT.** First-year salary and benefits guaranteed. Corporate association after one year. Located in a family-oriented, economically strong small city surrounded by four-season recreational and scenic Kettle Moraine area 30 miles north of metropolitan Milwaukee. Contact Hans W Schmelzling, Administrator, 279 S 17th Ave, West Bend, WI 53095; ph 414/338-1123. 7tfn/87

Great opportunity for GP/Family Physician needed to work in busy growing practice. No investment required. Established practice with guaranteed patient base. Good base salary plus incentive and potential for growth for the right doctor. Vacations and insurance paid. Reply to C H S, PO Box 641, Moline, IL 61265. 5-6/88

Pediatrician and **General Internist** or Family Practitioner (husband/wife team?) for multi-specialty clinic 50 miles southeast of Chicago in university town in Dunes County of southern Lake Michigan. Superior schools, many recreational opportunities, small town atmosphere. Pediatrician to join long established pediatrician with extensive practice. Four minutes from 400-bed hospital with NICU, ICU, and CCU. Contact Thomas Covey, MD, FAAP, 219-462-4167. p5-7/88

Family Practitioner. Clinic seeking a well-rounded physician to practice at a growing established satellite clinic 30 miles north of main clinic. Clinic located in a friendly rural community with year-round outdoor activities. Send CV to Artwich Clinic, Ltd, 815 South Main, Oconto Falls, WI 54154. p5-6/88

Rheumatologist—the Racine Medical Clinic a 34-physician multispecialty group conveniently located between Chicago and Milwaukee. Well equipped clinic offering salary guarantee with incentive bonus; excellent fringe benefits and early ownership. Please send curriculum vitae to: R D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 11tfn/87

Internal Medicine. Board-certified or eligible to join five general internists in a multispecialty group in northeastern Wisconsin. Office is next to two hospitals. Partnership is available after one year. Send CV to Dept 613 in care of the Journal. p4-9/88

Family Practice physician. Challenging opportunity, Northeastern Wis; salary plus benefits, rural community health centers, hospital practice not required, tourist area, national forest. Contact Northern Health Centers, PO Box 179, Lakewood, WI 54138; ph 715-276-6321. p4-6/88

Family practice. Thirty-four physician multispecialty group conveniently located between Chicago and Milwaukee. Well-equipped clinic offering salary guarantee with incentive bonus; excellent fringe benefits and early ownership. Please send current curriculum vitae to Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 4tfn/88

Full-time position of eight 24-hour shifts available in NE Wisconsin community hospital with annual ED volume of 10,000. Pleasant town located on Lake Michigan just 70 miles north of Milwaukee. $95,000 plus paid malpractice insurance. Please respond with CV to Dan Brachman, Vice President, Marketing, 2300 Western Ave, Manitowoc, WI 54220. p4-5/88

Primary Care Physician to work in Urgent Care Department of Dean Medical Center on part-time or full-time basis. Excellent back-up services. Complete lab and x-ray on site. Attractive opportunity including guaranteed salary, profit sharing, fringe benefits, and stockholdership. Send CV to Louis C Bernhardt, MD, Chairman, Recruiting Committee, Dean Medical Center, 1313 Fish Hatchery Rd, Madison, WI 53715. Equal Opportunity/Affirmative Action Employer. 5-6/88

The physicians on staff at Group Health, Inc. comprise one of the oldest and largest multi-specialty group practices in the Midwest. Group Health, Inc. is primarily a staff model HMO, with affiliations with a number of respected medical groups and referral specialists throughout the Twin Cities area.

If you are board certified, or board eligible, in any of the following specialties, Group Health, Inc. may have an opportunity for you.

- Adult Psychiatry
- Cardiology
- Dermatology
- Family Practice
- Internal Medicine
- Obstetrics & Gynecology
- Ophthalmology
- Pediatrics
- Urology

For information about joining the Group Health, Inc. medical staff, call Jerry Hess at **(612) 623-8444.**

Group Health, Inc.
2829 University Avenue S.E.
Minneapolis, Minnesota 55414
3-6/88

ORTHOPEDIC SURGEON
NEUROSURGEON
PHYSIATRIST
Industrial Rehabilitation

Outpatient orthopedic clinic seeking additional physicians to join growing industrial rehabilitation center specializing in disability evaluation, treatment, medical management, functional capacity assessment, work-hardening programming and employer consultation services. Part-time and full-time opportunities. Excellent guaranteed salary with incentives plus excellent fringe benefits. Please send CV to:

Bone & Joint Surgery Associates
Chiron Rehabilitation Clinic
2704 Marshall Court
Madison, Wisconsin 53705
(608) 231-3030 4-6/88

NEW PHYSICIANS FOR WISCONSIN
is seeking
• Family Physicians • Pediatricians
• Orthopedic Surgeons • Internists
Contact: Fred Moskol
UW Office of Rural Health
810 University Bay Drive
Madison, WI 53705
608/263-7933
7-12/87; 1-6/88

Beloit Clinic, SC, an expanding multispecialty group in southern Wisconsin college town is seeking a pulmonologist, a gastroenterologist, and a general surgeon with vascular capabilities for its main facility, as well as a family practitioner for a satellite location. Guaranteed salary with incentive plus excellent fringe benefits. Send CV to J F Ruethling, Administrator, 1905 Huebbe Parkway, Beloit, WI 53511; ph 608/364-2200. 4-6/88

PHYSICIANS EXCHANGE

continued

Physicians needed full- or part-time to perform light physicals. Milwaukee area. Professional liability provided. Phone 414/344-2100, Ms Jenkins. 10tfn/84

OB/GYN, Board-certified or eligible, to join highly progressive, rapidly growing practice. Normal and high risk obstetrics emphasized along with highest levels of infertility care (microsurgery, GIFT, IVF, Laparoscopic Laser Surgery), as well as extensive gynecology and surgery practice. Easy lake country or Milwaukee suburban living. Salary and guarantees to meet your needs with opportunity for partnership in one year. Available July 1988, or earlier. Contact Matt Meyer, MD, Women's Health Care, SC, Milwaukee Regional Fertility Center, 426 W Main St, Waukesha, WI 53186; ph 414/549-1333. 3-5/88

Excellent opportunity for a Board certified or eligible **ob/gyn** to practice in conjunction with a 4-member OB/GYN Department of a 28-member multispecialty group. The group is located in southeastern Wisconsin, in a city of 100,000 between two major metropolitan areas. If interested, please send CV to: William H Olson, Kurten Medical Group, 2405 Northwestern Ave, Racine, WI 53404. All inquiries will be kept confidential. 5tfn/86; c1tfn/88

Twenty-nine physician multispecialty clinic located in desirable East Central Wisconsin location is seeking Board-certified or Board-qualified orthopedic surgeon to round out its services. Lab, x-ray, excellent hospital. Liberal guarantee and benefits. If interested contact D F Sweet, MD, Fond du Lac Clinic, SC, 80 Sheboygan St, Fond du Lac, WI 54935. 9tfn/87

Primary Care Physicians—Family Practice, General Practice, or ER experience desirable. To staff clinics for industrial, walk-in, after hours, and satellite medicine. Excellent opportunity—guaranteed salary, profit-sharing, great fringes. Send CV to Administrator, Manitowoc Clinic, PO Box 3008, Manitowoc, WI 54220. p7-12/87; 1-5/88

Family Practice—Madison, Wisconsin. Eleven-year-old staff model HMO has a family practice position available. We offer a very attractive practice setting with reasonable scheduling, excellent salary and benefits. Contact: John Hansen, MD, Medical Director, Group Health Cooperative, One South Park, Madison, WI 53715; ph 608/257-9700. 4-6/88

Family Practice Clinic in central Wisconsin seeking family practitioner for a five-man group with two locations. Excellent compensation and fringe benefits. Send CV to John Thompson, MD, at 315 First St, Nekoosa, WI 54457 or call collect at 715/886-3175. p4-5/88

Wisconsin. OB/GYN (BC/BE) needed to join dynamic HMO-based multispecialty group practice. University town of 55,000 near Minneapolis. Community and recreation outstanding. Competitive salary and fringes. We take pride in our patient care. Contact Robert A. Braastad, MD, Group Health Cooperative, 1030 Regis Court, Eau Claire, WI 54701; ph 715-836-8552. p5/88;6-9/88

Busy Neonatologist seeks BC/BE associate for July 1988 to share growing Level II plus private practice fee-for-service unit covering more than 4200 deliveries in southeastern Wisconsin. Reply with CV and references to Dept 618 in care of the Journal. p5-6/88

The Wausau Medical Center is seeking BE/BC individuals in the following specialties: Cardiology, Dermatology, Family Practice, Infectious Disease, Obstetrics/Gynecology, Pediatrics and Rheumatology. Modern clinic facility located across the street from modern 300-bed hospital. Full partnership in three years. Easy access to lakes, woods and mountains. Write including CV to D K Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, WI 54401. p4tfn/88

BC/BE General Internist to join 26-MD multispecialty group with four internists, one nephrologist and one gastroenterologist. Top salary first year, full incentive thereafter. Central Wisconsin university town with drawing area of 80,000. Send CV to Dr John Gauder, Rice Clinic, SC, 2501 Main St, Stevens Point, WI 54481, or call collect 715/344-4120. 12tfn/87

Pediatrician (BC/BE) to join five dynamic BC pediatricians in a 38-physician multispecialty group. Newborn stabilization skills required. Teaching environment with residents on service six out of 12 months. Cultural and outdoor recreational opportunities excellent. Send CV to Kurt Heyrman, MD, 401 North Oneida St, Appleton, WI 54911. 4-6/88

Family Practice, Pediatrics, and Internal Medicine—Park Crest Medical Clinic in suburban Milwaukee has immediate openings in these three specialties. For more information, please contact Sherry VanErt, 2665 S Moorland Rd, New Berlin WI 53151: ph 414/786-1199. p4-7/88

Eagle River—Great opportunity for two BC/BE family practice physicians to join well-established practice. Guaranteed annual income and future partnership available. For more information, send resume to Judy Harris, Recruiter, UW Office of Rural Health, 810 University Bay Dr, Madison, WI 53705 or call collect 608/263-7933. 1tfn/88

Emergency Medicine, Otolaryngologist, Urologist, and Obstetrician/Gynecologist to join multispecialty group practice in Woodruff, WI. Guaranteed annual income and excellent fringe benefit program. Send CV to R J Sloan, MD, Lakeland Medical Associates, Ltd, PO Box 549, Woodruff, WI 54568. 4tfn/88

MEDICAL FACILITIES

For Rent. Doctor's Office, Hales Corners, Wisconsin, area 1050 sq ft. New building, first floor, ample parking. Reception, business office, three plumbed examining rooms, laboratory, private office and bath. For information call 414-764-6692 or 414-744-8007. p5/88

MISCELLANEOUS

HOLTER MONITOR
Quality Scanning for reel or cassette type recorders by qualified technicians and certified cardiologists' interpretations, scan price $35.00 with UPS speedy delivery. Recorders loaned, leased, or purchase new dual-channel Holter recorders, $750.00, with two-year warranty. For more information call Advance Medical and Research Center 1-800/552-6753. 11tfn/85

REAL ESTATE

Secluded NW Wisconsin retreat. Forty acres, 550' frontage on uninhabited 30 acre lake. Beautiful six sided, two story, three bedroom, full basement, custom modern home. Complete privacy, wildlife, and large pines. For more information write or call Buck McMinn, Chelan, WA 98816; ph 509-682-5204. p5-6/88

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MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

WISCONSIN

JUNE 2, 1988: *Gastroenterology for the Practicing Physician* at Red Carpet Hotel/Airport, 4747 South Howell Ave, Milwaukee. Sponsored by The Center for Digestive Disorders at Trinity Memorial Hospital, and Merck, Sharp & Dohme Pharmaceuticals. 9:30 am–3:30 pm. Lunch provided. No charge. Course director, Joseph E Geenen, MD. Info: James G Streed, Trinity Memorial Hospital, 5900 South Lake Dr, Cudahy, WI 53110; ph 414/769-4050. g2tfn/88*

JUNE 3–4, 1988: Wisconsin Radiological Society and the Milwaukee Roentgen Ray Society, American Club, Kohler. g11-12/87;1-5/88

JUNE 16–19, 1988: Wisconsin Academy of Family Physicians, Holiday Inn, Stevens Point. g10tfn/87

JULY 21–23, 1988: *Wisconsin Society of Obstetrics and Gynecology,* Landmark Resort, Egg Harbor. g1-6/88

JULY 29–31, 1988: Wisconsin Dermatological American Club, Kohler. 12tfn/87

AUGUST 3–8, 1988: *"International Doctors In Alcoholics Anonymous,* Stouffer Hotel, Baltimore, MD. Info: Information Secretary, IDAA, 1950 Volney Rd, Youngstown, OH 44511; ph 216/782-6216. g1-7/88

SEPT 9–11, 1988: Wisconsin Society of Anesthesiologists, Convention Center/Embassy Suites, Green Bay. g10tfn/87

OCTOBER 1, 1988: *Wisconsin Society of Radiation Oncologists,* Concourse Hotel, Madison. 4tfn/88

OCTOBER 3–7, 1988: 54th Annual Scientific Assembly of the American College of Chest Physicians, Anaheim Convention Center, Anaheim, Calif. Info: Division of Education, American College of Chest Physicians, 911 Busse Highway, Park Ridge, IL 60068; ph 312-698-2200. g5-8/88

OCTOBER 20–21, 1988: Wisconsin Chapter, American College of Emergency Physicians, The Abbey, Lake Geneva. 2tfn/88

NOVEMBER 4, 1988: *Wisconsin Orthopaedic Society,* Olympia Resort, Oconomowoc. 4tfn/88

AMA

JUNE 26–30, 1988: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 4–7, 1988: Interim House of Delegates, Dallas, TX.

JUNE 18–22, 1989: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 3–6, 1989: Interim House of Delegates, Honolulu, HI.

JUNE 24–28, 1990: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 2–5, 1990: Interim House of Delegates, Orlando, FL.■

Wisconsin Specialty Society Meetings 1988

- Wisconsin Radiological Society and the Milwaukee Roentgen Ray Society, June 3–4, 1988, American Club, Kohler.
- Wisconsin Academy of Family Physicians, June 16–19, 1988, Holiday Inn, Stevens Point.
- Wisconsin Society of Obstetrics and Gynecology, July 21–23, 1988, Landmark Resort, Egg Harbor.
- Wisconsin Society of Anesthesiologists, Sept 9–11, 1988, Convention Center/Embassy Suites, Green Bay.
- Wisconsin Society of Internal Medicine, Sept 15–17, 1988, Milwaukee Marriott.
- Wisconsin Radiological Society, Sept 30–Oct 1, 1988, Concourse Hotel, Madison.

* * *

Specialty Society Meetings to be held in conjunction with SMS Annual Meeting, April 28–30, 1988, Milwaukee

- Wisconsin Allergy Society
- Wisconsin Society of Anesthesiologists
- Wisconsin Chapter, American College of Emergency Physicians.
- Wisconsin Academy of Family Physicians
- Wisconsin Society of Pathologists
- Wisconsin Society of Physical Medicine and Rehabilitation
- Wisconsin Society of Radiation Oncologists

LYME DISEASE: The New Health Hazard of Summer

CME Conference

Friday, June 3, 1988

Marshfield Clinic
Marshfield, Wisconsin

Program Objective:
Lyme Disease, according to experts at the Centers for Disease Control, is the most common tick-borne disorder in the United States. In Wisconsin, Lyme Disease has become a matter of much concern since it is much more prevalent and possibly more dangerous than previously realized.

Topics to be addressed:
Historical Perspective of Lyme Disease
Clinical Spectrum of Lyme Disease
Immunodiagnostic Testing for Lyme Disease
Cutaneous Sequelae
Neuro-Ophthalmic Features of Lyme Disease
Neurologic Manifestations
Cardiology Manifestations of Lyme Disease
Pediatric Aspects of Lyme Disease
Lyme Disease: Are there Implications in Pregnancy?
Coping with Lyme Disease

Registration fee for this program is $50. 4½ hours of Category I Credit.

Requests for further information should be directed to the Office of Medical Education at the Marshfield Clinic 715-387-5207 or 1-800-782-8581, ext. 5207. 5/88

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 50¢ per word, with a minimum charge of $20.00 per listing. *All listings must be prepaid.*

BOXED LISTINGS: $25.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 15th of the month preceding the month of publication; *eg,* copy for the August issue is due by July 15. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 1-800-362-9080.

FOR LISTING of other meetings see the January 1, 1988 issue of the *Journal of the American Medical Association:* Continuing Education Opportunities for Physicians for period March 1988 through August 1988.

Joint Commission Schedules 1988 Teleconferences

The Joint Commission on Accreditation of Healthcare Organizations will present three teleconferences in 1988 as part of a continuing agreement with the Hospital Satellite Network (HSN). Each live two-hour, interactive teleconference offers insights into key areas of the Joint Commission's accreditation requirement. Broadcast schedule is:

July 7: "Managing Hazardous Materials and Wastes: The Joint Commission Approach,"

Sept 1: "Medical Staff Quality Monitoring: Keys to Success,"

Oct 7: "Assuring the Quality of Ambulatory and Managed Health Care Services."

Teleconferences will each begin at 1:00 pm, Eastern time, and will be moderated by William Jessee, MD, vice president for education at the Joint Commission. To register for the teleconferences, call the Joint Commission's customer service unit at 312-642-6060, extension 650. g5tfn/88

State Medical Society of Wisconsin

Dates and locations of ANNUAL MEETINGS 1989–1993

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel, unless otherwise indicated.

1989—April 13–15
1990—April 26–28: ***Green Bay***
Convention Center, Embassy Suites
1991—April 18–20
1992—April 23–25
1993—April 15–17: ***La Crosse***
Convention Center, Radisson

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

BOOKS RECEIVED

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, William S Middleton Memorial Medical Library, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

Every Woman's Guide to The Body at 40. By Marjorie Shafto, MD, and Gerald L Hunt. Published by Perigee Books, 200 Madison Ave, New York, NY 10016. 1987. Pp 253. Price: $10.95.

Food Allergies. By Neil S. Orenstein, PhD, and Sarah L. Bingham, MS. Published by The Putnam Publishing Group, 200 Madison Ave, New York, NY 10016. 1987. Pp 161. Price: $9.95.

The Age of Miracles. By Guy Williams. Academy Chicago, Publishers, 425 North Michigan Ave, Chicago, IL 60611. 1987. Pp 234. Price: $16.95.

Adolescent Psychiatry. Edited by Sherman C Feinstein, et al. The University of Chicago Press, 5801 S Ellis Ave, Chicago, IL 60637. 1987. Pp 634. Price: $37.50.■

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Ms Kaltenberg

Ms Lord

Ms Schmeidlin

New SMS staff

Cindy Kaltenberg is the new SMS personnel administrator, replacing Mavis Minor, who retired in January. Ms Kaltenberg was employed by Lands' End of Dodgeville as supervisor of employee benefits. She holds a BA in personnel administration and insurance from the University of Wisconsin–Madison.

Karen Lord joined the SMS staff in March as a practice management specialist in the Division of Medical Policy and Practice. Ms Lord was employed by Wisconsin Physicians Service in Madison.

Heidi Schmeidlin joined the staff of SMS Services in March as an accounting administrative clerk. Ms Schmeidlin was employed by A Touch of Country in Lodi. She is a graduate of the Account Clerk Program at the Madison Area Technical College.■

MEDICAL EXAMINING BOARD

Walter G. Szymanski, MD, formerly of Milwaukee—revocation of license to practice medicine and surgery.

"The board found that Szymanski violated state law and the board's administrative code as a result of his obtaining and possessing controlled substances otherwise than in the course of legitimate professional practice and his conviction for six counts of second degree sexual assault for having sexual contact and sexual intercourse with a 14-year-old girl. Szymanski's license has been suspended since March 5, 1986." (News release, Jan 8, 1988.)

Luis Galang, MD, New London—revocation of license to practice medicine and surgery.

"The board found that Galang violated state law and the board's administrative code as a result of his Alford plea of no contest to four counts of aiding and abetting the unlawful possession of controlled substances. The board found that conviction of the crimes was substantially related to the practice of medicine." (News release, Jan 28, 1988.)

Jason D. Smith, DO, Glendale—voluntary surrender of license to practice medicine and surgery; conditions and limitations imposed on any application for licensure.

"The board found that Smith violated state law and the board's administrative code by engaging in unprofessional conduct in that his license to practice medicine and surgery and his controlled substances license in the State of Illinois were revoked as a result of the conviction of crimes for violation of federal law regulating the possession, distribution, or use of controlled substances." (News release, March 31, 1988.)■

THE INTRODUCTION to the "Monthly Disciplinary Report" issued by the State Department of Regulation and Licensing contains the following statements: "In some cases, the final order refers to attached exhibits or stipulations. In all cases where discipline is ordered, the final order includes a document which notifies the respondent of appeal rights. Generally, exhibits, stipulations, and notices of appeal rights are not copied in the attached materials. Copies of these documents may be obtained from the Department of Regulation and Licensing, PO Box 8935, Madison, Wisconsin 53708. Licensees who are disciplined have the right to seek judicial review of the final order issued in a case. Since cases in this report have been decided recently, orders may be included which are under appeal in court. The current status of a licensee can be determined by contacting the Department of Regulation and Licensing at 608/267-7211." Administrative policy for providing information on disciplinary actions appeared in the September 1987 issue of the *WMJ*.

Before prescribing, see complete prescribing information in SK&F LAB CO. literature or PDR. The following is a brief summary.

Contraindications: There are no known contraindications to the use of 'Tagamet'.

Precautions: While a weak antiandrogenic effect has been demonstrated in animals, 'Tagamet' has been shown to have no effect on spermatogenesis, sperm count, motility, morphology or in vitro fertilizing capacity in humans.

In a 24-month toxicity study in rats at dose levels approximately 9 to 56 times the recommended human dose, benign Leydig cell tumors were seen. These were common in both the treated and control groups, and the incidence became significantly higher only in the aged rats receiving 'Tagamet'.

Rare instances of cardiac arrhythmias and hypotension have been reported following the rapid administration of 'Tagamet' HCl (brand of cimetidine hydrochloride) injection by intravenous bolus.

Symptomatic response to 'Tagamet' therapy does not preclude the presence of a gastric malignancy. There have been rare reports of transient healing of gastric ulcers despite subsequently documented malignancy.

Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chlordiazepoxide, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.), demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. (Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.)

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

Adverse Reactions: Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states (e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation), predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving 'Tagamet', particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in 'Tagamet'-treated patients (approximately 1 per 100,000 patients), including agranulocytosis (approximately 3 per million patients), have been reported, including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia (approximately 3 per million patients) and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly unlikely. A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving 'Tagamet' has been reported.

How Supplied: Tablets: 200 mg. tablets in bottles of 100; 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only); 400 mg. tablets in bottles of 60 and Single Unit Packages of 100 (intended for institutional use only), and 800 mg. Tiltab® tablets in bottles of 30 and Single Unit Packages of 100 (intended for institutional use only).

Liquid: 300 mg./5 ml., in 8 fl. oz. (237 ml.) amber glass bottles and in single-dose units (300 mg./5 ml.), in packages of 10 (intended for institutional use only).

Injection:

Vials: 300 mg./2 ml. in single-dose vials, in packages of 10 and 30, and in 8 ml. multiple-dose vials, in packages of 10 and 25.

Prefilled Syringes: 300 mg./2 ml. in single-dose prefilled disposable syringes.

Plastic Containers: 300 mg. in 50 ml. of 0.9% Sodium Chloride in single-dose plastic containers, in packages of 4 units. No preservative has been added.

ADD-Vantage®* Vials: 300 mg./2 ml. in single-dose, ADD-Vantage® Vials, in packages of 25.

Exposure of the premixed product to excessive heat should be avoided. It is recommended the product be stored at controlled room temperature. Brief exposure up to 40°C does not adversely affect the premixed product.

'Tagamet' HCl (brand of cimetidine hydrochloride) injection premixed in single-dose plastic containers is manufactured for SK&F Lab Co. by Travenol Laboratories, Inc., Deerfield, IL 60015.

* ADD-Vantage® is a trademark of Abbott Laboratories.

BRS-TG:L73B Date of issuance Apr. 1987

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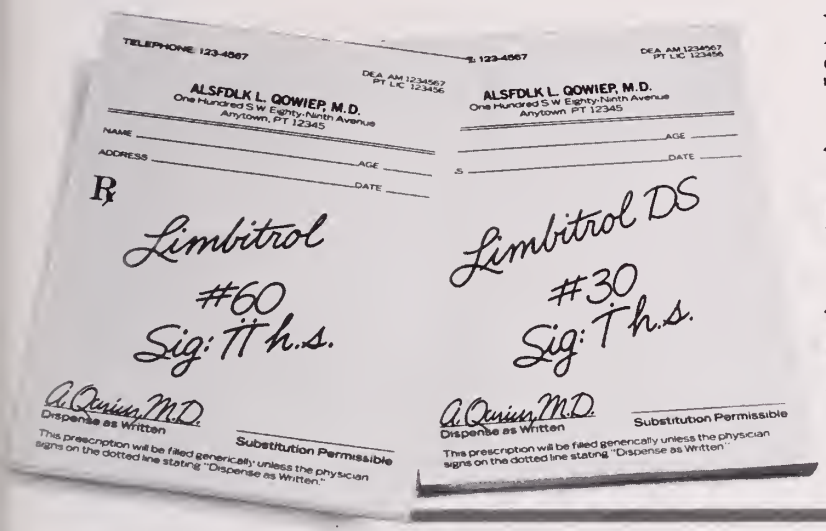

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References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner VP, *et al: Psychopharmacology 61:*217-225, Mar 22, 1979.

Limbitrol®Ⓒ
Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.**

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady- state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.
Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. *Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. *Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. *Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. *Endocrine:* Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

How Supplied: *Double strength (DS) Tablets,* white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets,* blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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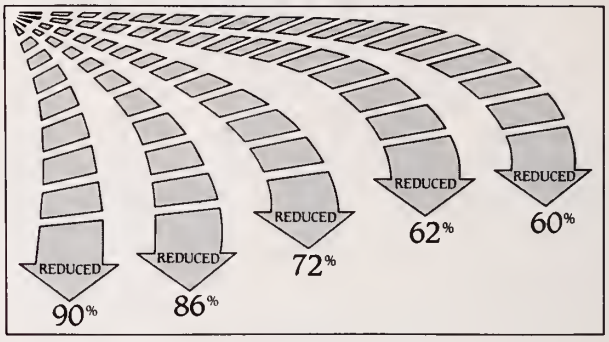

*Patients often presented with more than one somatic symptom.

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WISCONSIN MEDICAL JOURNAL

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STACKS

Newborn screening . . . The Wisconsin Division of Health begins a new screening program for sickle cell disease and provides the *WMJ* with a primer (see page 21).

Why medicine? . . . Graduating medical students reveal when they first decided to become physicians and who most influenced their decisions (see page 23).

Writing contest . . . The winners of the first annual *WMJ* Writing Contest received their awards at the SMS Annual Meeting (see page 26). The winning papers begin on pages 27 and 31.

Under the dome . . . The *WMJ* reviews state legislation of interest to SMS members during the 1987 session (see page 41).

House of Delegates . . . Delegates to the 1988 SMS Annual Meeting took action on a large number and wide variety of resolutions and reports (see page 49).

June 1988

V.87, NO.6

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THE STATE MEDICAL SOCIETY OF WISCONSIN, created by the Territorial Legislature in 1841, represents nearly 7000 member physicians in Wisconsin, comprising 55 county medical societies and 28 medical specialty sections. The purpose of the Society is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society include continuing medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, services for physicians, operation of a Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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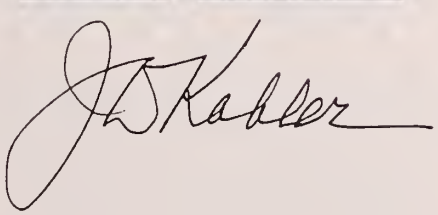
The challenge of service

The State Medical Society of Wisconsin is strong, well represented, well managed and well regarded. Our Society enjoys—to a degree rare among comparable medical associations—the confidence, support and participation of its members. And we can point with pride to our Society's publications, the energy and credibility of its communications with public officials, and its prompt responsiveness to the many issues arising from an unstable health care environment.

Nevertheless, there are unresolved matters which some view with alarm: the refractory professional liability crisis, the destabilization of health care systems familiar to and trusted by most patients, damaging excesses in marketing and cost shifting, and the growth of politically driven regulations intended to allocate constrained health resources equitably. There is an abundance of other problems which challenges us: the high costs of medical education with the resultant severe debt burden borne by young physicians, a concurrent declining commitment to primary care, a shortage of professional nurses which will worsen for the next several years, and growing threats from as yet incurable infections and degenerative diseases.

Is it possible, despite these contemporary problems which appear so large because they are so close, to look to the future with confidence? I think it is, and I think we should.

Some problems *are* solved. In 1948, the infant death rate was more than three times that of today, maternal mortality was 26 times that of today, and poliomyelitis was a major problem. Although we now have AIDS and Alzheimer's disease with which to contend, our profession is younger, more numerous, better educated, and armed with more powerful means to cure, to palliate, and to comfort than ever before.



The recently adopted SMS Strategic Plan puts forth many proposals for the future. Of course, not all can, or should, be implemented immediately, and some will oblige substantial thought and discussion. Implicit among the latter are two which I wish especially to stress:

1. What if our current efforts toward tort reform do not prevail or do not suffice? We need now to examine and consider a more fundamental remedy—a defined compensation plan for patients with serious unwanted outcomes which is not contingent upon a legal lottery or an artificial assignment of imputed negligence.

2. We should plan and fund improved communication with the people of Wisconsin now. Activities to enhance the reputation and credibility of our profession should include descriptions and explanations of physicians' many contributions to the health of the public.

Whatever the outcome of our current and future deliberations, to judge from the past one can predict that our profession and our Society will not merely survive, but will surmount the problems of our day and conscientiously continue to serve the people of Wisconsin. Serving with you in the year to come will be an honor and a challenge; I look forward to it with pleasure and optimism.■

Exactly 5 cents

DO YOU REMEMBER when a nickel was a significant bit of currency? It could purchase an Eskimo pie, a bag of Planter's salted peanuts, a roll of Lifesavers, a package of chewing gum (with such interesting old flavors as Beeman's pepsin and Adams Blackjack as well as Wrigley's PK's and Juicy Fruit), generous candy bars (such as Baby Ruth, Oh Henry and Hershey's, with or without a generous portion of almonds) and cigars, or a bag of Bull Durham to roll your own. Half of the items at Woolworth's Five and Ten Cent store sold for a nickel and gave rise to that tuneful ditty entitled "I Met a Million Dollar Baby in the Five and Ten Cent Store." There was a political slogan that stated, "What this country needs is a good five cents cigar."

And just what does this nostalgic trip have to do with a medical journal? Last week I received a check from an insurance company for exactly five cents. This was accompanied by a detailed two-page letter of explanation. In this case, I was the insured and that was the amount due me after the insurance company had belatedly paid a physician $4.76. The major medical total coverage was $5.96 and the insurance company was to pay 80% of that. This amounted to $4.76, which was duly paid to the physician. The interest payable came directly to me.

This came about because of the law which penalizes insurance companies for not making prompt payments. Although it is true that physicians and hospitals appreciate being paid promptly, this situation has been carried to a ridiculous extreme.

I would estimate that it probably cost the insurance company about $25 to pay the postage and do all the accounting, letter writing, and check writing. It was embarrassing to cash the check for a nickel, but I was afraid that additional expense with accounting would be involved if the check was not returned.

It would seem reasonable to have a reverse cap, perhaps a basement or bottom line, for figures so ridiculously low that they should simply be written off. The cost of sending out this check for a nickel, of course, has to be added to the medical insurance premium. Besides, what's available for five cents these days?

—*Victor S. Falk, MD,* Edgerton

Editor's note: The SMS has opposed the campaign by some insurers to eliminate their legal obligation to pay interest on claims not processed in a specific time. This obligation was imposed because some physicians were forced to secure loans to cover cash flow shortages while waiting for late payments from insurers. The letter Dr Falk received is typical of letters periodically sent as part of this campaign, and the issuing of a 5-cent check was unnecessary—insurers have other options available. For further information, contact Terry Hottenroth, director, SMS Division of Public Affairs.

AIDS Prevention

INASMUCH AS WE lack the will to tackle the AIDS problem at its source, at the level of promiscuous homosexuality and dirty-needle-intravenous-illicit-drug use, we are condemned to employ secondary control measures as we watch the incidence of AIDS double annually in Wisconsin.

Much has been learned about this twentieth century infectious disease, but response has been more emotional than intellectual, generally even at the hospital level where dealing with an infectious process should be second nature. Perhaps we ought to step back, look at what we know for sure, and try to come up with a rational course of action which won't be too disruptive of the daily routine.

We know, for instance, that except for the two circumstances cited above AIDS is hard to catch, and we know how it is spread.

We know that if virus-loaded bloody fluids come into contact with broken skin or mucous membranes, there is a chance for transmission—but we know, too, that the virus is easily killed outside of the body, and that latex barriers and goggles are probably effective preventive measures. And we know that very few nurses, doctors and technicians have acquired AIDS in the work place, presumably in spite of all sorts of breaks in technique, needle sticks, etc.

And finally, we know that testing for the AIDS virus is imperfect, has a lag period, and produces false positives.

So what do we do?

1. We stay calm.

2. We educate our medical personnel, and we stay current and flexible.

3. We presume everyone is potentially infectious—ie, we treat all specimens and drainage as though the source patient has AIDS. This will improve discipline on the part of

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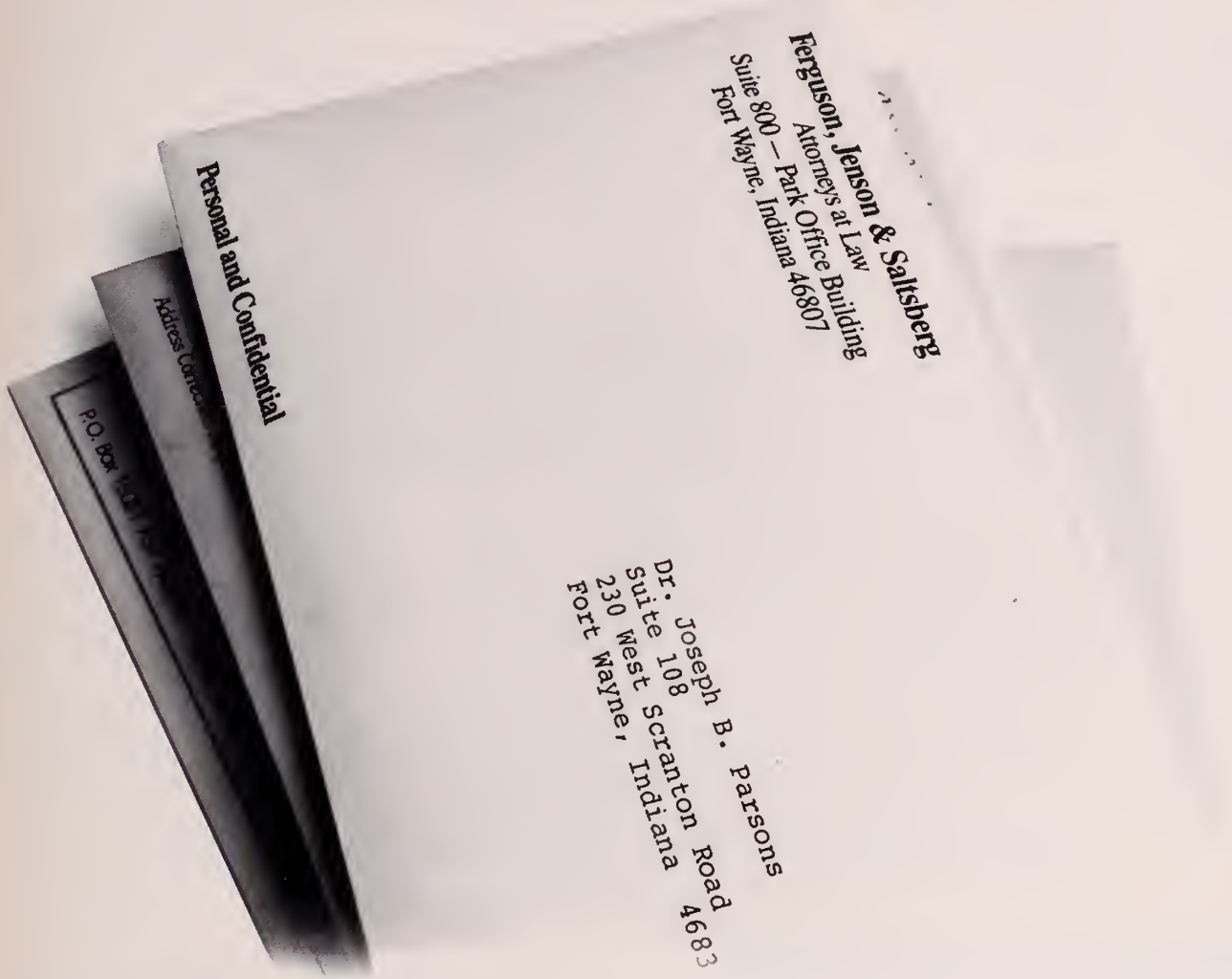
Crisis in black and white.



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health care personnel and improve patient care. Nosocomial infections will go down in frequency.

4. We test selectively within guidelines handed down from the various authorities. (Surely mandatory preadmission testing is an option, and is being tried, but until better tests come along it will not be widely adopted. There is nothing, however, to prevent individual physicians with high risk practices to insist on testing in their own practices.)

We treat everyone who needs treatment. We don't run out on patients with other infectious diseases; we must not do so on patients with AIDS.

Some day, if the incidence of AIDS continues to double annually, society will be willing to address the source of the problem. Until then we will talk about giving the addicts clean needles and peddling condoms in schools, and keep right on deluding ourselves.

—*Wayne J. Boulanger, MD*
Milwaukee

Surgeons and AIDS

THERE IS A mounting controversy regarding whether surgeons have an obligation to operate upon patients with AIDS. There are indeed moral, ethical, and practical considerations. An experience I had while a resident influences my view.

As a third-year surgical resident, I was being assisted by a senior resident in a difficult abdominal operation. I accidentally introduced a needle deep into his finger, thereby inoculating him. A few weeks later he developed hepatitis. He became so ill he required hospitalization and ended up remaining at home for almost six months, thereby extending his training program. I felt very guilty that I was responsible for his illness. Having had this experience, were I responsible for inoculating an assistant with the AIDS virus and that person died, I would be more than merely distraught.

Thought should be given to the medical/legal aspects of such a scenario. Most likely the senior resident could have successfully sued me had I had any net worth at the time.

It may be easy for some physicians who do not work in the operating room and who are not at risk for being inoculated during a procedure to advise surgeons of their responsibilities. One must remember that not only are the surgeons and their assistants at risk but also everyone on the operating team, including the circulating nurse who must dispose of blood-soaked sponges. Preoperative testing for the AIDS virus should be mandatory. Those in the operating theatre and those on the wards should know when they are at high risk so they can take special precautions.

—*Richard D. Sautter, MD,* Marshfield

Editor's note: At its 1988 Annual Meeting, April 29, the SMS House of Delegates rejected a call for routine HIV-antibody tests for prospective surgical patients.

LETTERS

TO THE EDITOR: The following poem was written by a gentleman who, at 72 years of age, has done remarkably well in terms of changing his life style in response to his hyperlipidemia and diabetes. His enthusiasm for living is infectious and his sensitivity for the medical profession as a whole is expressed very clearly in his poetry.

—*Robert E. Stader, MD*
Lancaster

Doctor who?

In medicine, one must admit,
are many ways to benefit
in curing mankind's countless ills,
with tinctures, tonics, balms and pills.

This science is diversified
for men, who are so qualified,
to practice for the good of man,
eliminating ache and pain.

The surgeon with his touch and knife,
has talents, which can save a life.
The internist will never cease,
in diagnosing one's disease.

Psychiatrists are known as shrinks,
in analyzing what one thinks.
They may repose you in a slouch
on what turns out to be a couch.

Some specialize to find a cure
for something hidden and obscure.
And in most cases they will find
the answer, which may ease our mind.

Hippocrates of yesterday
would gladly nod his head today
at what he had started in BC
and how it all became to be.

Of all the doctors everywhere
around this our hemisphere
there is one and we all agree:
the family doc, we call GP.

He always is the first to know,
what's ailing us from head to toe.
His diagnosis sets the pace
for further treatment in each case.

At times, the GP will enlist
the service of a specialist.
In any case, it's wise to see
our favored doctor: the GP.

—Otto K. Dannenmann

Medical directors and administrators

TO THE EDITOR: The resident mix in today's long-term care facility no longer reflects the picture of ten years ago, when most patients required little more than bedside nursing and were chronically ill. Today there are nursing homes with ventilator-dependent patients, brain-damaged adults, AIDS patients, Alzheimer's victims, subacute-intensive skilled care DRG patients, and the chronically ill. The need for and the role of a medical director has changed. There is a need to be directly and continually involved in all aspects of care from the admission assessment to ongoing resident responsibility.

This is no longer a paper compliance position but a position which requires the overall coordination of the medical care provided to ensure that adequate and appropriate services are provided to all residents. This is accomplished not only by ensuring that the attending physician is providing services to appropriately meet the medical needs of the resident, but also by interacting with various departments within the facility to implement and coordinate methods which will produce quality care outcomes.

The changing role of the medical director can be of benefit to the nursing home administrator, just as the role of the administrator can be of benefit to the medical director. These two positions need to work together, since their common objective is to ensure that quality care is provided and that the quality of life is enhanced for the residents of the nursing home.

The nursing home administrator needs to be knowledgeable about the duties and responsibilities of the medical director, just as the medical director needs to be aware of administrative policies governing the nursing home. This can be accomplished only through an ongoing communication system. Examples of effective communication might involve regular meetings of the medical director and the administrator to discuss concerns or changes in rules, regulations or facility policies, and a monthly tour of the facility by the administrator and medical director to evaluate the quality of care and the quality of life. Such tours can be incorporated as part of the overall quality assurance program.

The medical director and administrator not only need to fulfill the basic requirements of their positions, but must also look at their overall responsibilities and objectives. Quality care requires a good working relationship between these two positions. An objective of quality care requires a philosophy of mutual trust and shared decision-making. We need to work together, not at cross purposes, to further the quality of care and quality of life of nursing home residents.

—*Phyllis T. Williams, NHA*
Countryside Home
Jefferson■

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Ruptured abdominal aortic aneurysm: Mortality, prognostic factors, and long-term survival

Thomas H. Cogbill, MD,
Pamela J. Strutt, RN, and
Fred A. Schaldach, MD, La Crosse

ABSTRACT. *The experience with ruptured abdominal aortic aneurysms (AAA) in patients at a single institution during an 11-year period was reviewed to determine the effect of recent advances in critical care on early survival. Long-term follow-up was established for all survivors, and their five-year survival rate was calculated by the life-table method.*

From January 1976 to December 1986, 70 patients were treated surgically for ruptured AAA. Ages ranged from 46 to 93 ($\bar{x}$ = 72). The overall hospital mortality rate was 66%. Hospital mortality from 1976 to 1981 was 75% v 53% from 1982 to 1986 (P = 0.055). Twenty-three survivors (96%) required mechanical ventilation for an average of six days. Pressor support was necessary for 14 survivors (58%). Pulmonary artery catheters were used in 22 (92%) and nutritional support was required by 14 (58%). The five-year survival rate for 24 patients discharged after ruptured AAA repair was 67%, and 94% of the survivors are fully ambulatory.

The factors most predictive of a poor outcome after AAA rupture were advanced age, prolonged hypotension, and oliguria. Operative mortality after repair of ruptured AAA remains high. Survivors routinely require advanced critical care techniques. Long-term survival and function of those successfully resected are excellent.

Key words: abdominal aortic aneurysm, ruptured aneurysm, shock

REPAIR OF A RUPTURED infrarenal abdominal aortic aneurysm (AAA) remains one of the most challenging surgical emergencies. As the operative mortality of elective AAA repair has declined to 2% to 4% in most centers,[1-4] the perioperative mortality associated with ruptured AAA repair continues to be more than 40% in most recent reports.[1,3,5-8] The extent and technology of critical care techniques used in the postoperative management of these patients has grown exponentially. The long-term survival and function of patients discharged after successful repair, however, have not been previously addressed.

The experience with ruptured AAA repair in patients at a single institution during an 11-year period was reviewed to identify factors predictive of survival and to determine the effect of recent critical care advances. Long-term follow-up was established for all survivors to determine late survival and level of function.

Patients

During the 11-year period ending December 1986, 70 patients underwent repair of ruptured infrarenal AAA at the Gundersen-Lutheran Medical Center. Thoracic aortic aneurysms, thoracoabdominal aortic aneurysms, and symptomatic, unruptured aneurysms were excluded from study. Patients ranged in age from 46 to 93 ($\bar{x}$ = 70). There were 58 men (83%) and 12 women (17%).

The Gundersen-Lutheran Medical Center is a referral medical complex staffed by 200 full-time medical and surgical specialists. The hospital serves as a referral center for parts of Wisconsin, Iowa, and Minnesota. Patients in this series were often stabilized at small community hospitals before being transferred to La Crosse.

Method

Hospital charts were reviewed for medical history, clinical presentation, procedures, perioperative monitoring, mortality, complications, and discharge disposition. Follow-up was conducted for the 70 patients, and all of the survivors were contacted by telephone for completion of a lifestyle questionnaire. Survival data through five years were determined by the life-table method and compared with the general population matched for age, sex, and race.[9,10] Comparisons of results were made between groups using x^2 analysis of two proportions with Yates' correction or Fisher's exact test, where appropriate. The level of confidence was defined at $P<0.05$.

Results

Twenty-six patients (37%) were admitted to the emergency department with systolic blood pressure less than 90 mmHg. Forty-five patients (64%) were transferred to the operating room in less than one hour. Fifty-nine (84%) were taken to the

From the Department of General and Vascular Surgery, Gundersen-Lutheran Medical Center, La Crosse. Reprint requests to: Thomas H. Cogbill, MD, Department of Surgery, Gundersen Clinic, Ltd., 1836 South Ave, La Crosse, WI 54601 (phone: 608-782-7300). Copyright 1988 by the State Medical Society of Wisconsin.

ACKNOWLEDGEMENTS: The authors gratefully acknowledge the support of the R. James Trane Surgical Data and Research Center of the Gundersen Medical Foundation.

operating room in less than eight hours, and nine (13%) were delayed eight hours or longer. Proximal vascular control was gained at the infrarenal aorta in 47 patients, the diaphragm in six, and the thoracic aorta in two. A Foley catheter was used to achieve control in four. Woven Dacron prostheses were placed in 57 patients (81%), including 24 straight tube grafts, 25 aortoiliac bifurcation grafts, and eight aortofemoral grafts. Over-sewing of the infrarenal aorta and a delayed extra-anatomic bypass were performed in one patient. Twelve patients (17%) died in the operating room before a graft could be completed.

Thirty-one patients died within 24 hours of being admitted. The cause of death for 25 was related to ongoing hemorrhage or severe, refractory coagulopathy. Four patients died as the result of an acute, massive myocardial infarction. Fifteen patients died from two to 99 days after the initial operation. The causes of late death were multiple organ failure in association with sepsis (nine), ischemic bowel complications (three), renal failure (two), and pulmonary embolus (one). Twenty-four patients survived ruptured AAA repair and were discharged from the hospital. Overall hospital survival for the entire series was 34% (Table 1).

Table 1—*Results after ruptured AAA in 70 patients*

Intraoperative deaths	12 (17%)
Deaths within 24 hours	19 (27%)
Late hospital deaths (2-99 days)	15 (22%)
Survived and discharged	24 (34%)

Predictive factors

The time from admission to the operating room, the size of the aneurysm, the site and extent of rupture, and the location of the aortic cross clamp had no predictive value in determining survival. Although the survival rate for males was 38% *v* 17% for females, this difference was not statistically significant ($P = 0.09$).

Advanced age was associated with a significantly reduced rate of survival. Fifty-four percent of patients younger than 70 survived *v* 24% of those 70 and older ($P = 0.007$) (Table 2). Four patients older than 80, however, were ultimately discharged. The oldest survivor was 88 years old.

Table 2—*Survival after ruptured AAA by age group*

Age	*Survival*
<70 years	13/24 (54%)
70-79 years	7/27 (26%)
>80 years	4/19 (21%)

Systolic blood pressure upon arrival in the operating room was a highly significant predictor of survival. There were no survivors of those patients with systolic blood pressure below 60 mmHg. In contrast, 51% of the patients with systolic blood pressure greater than 100 mmHg survived. This difference was significant ($P = 0.028$).

The amount of blood transfused in the operating room was not predictive of survival. The chance of survival after transfusion of fewer than 10 units, 11-20 units, and more than 20 units, was 34%, 36%, and 30% respectively.

Urinary output of less than 50 ml during the entire operation was incompatible with survival in our series. Fifty percent of the patients with more than 50 ml of urine output survived ($P = 0.0002$).

Critical care techniques

The hospital course of the 24 survivors was closely analyzed. The mean hospital stay was 26 days. The mean stay in the intensive care unit was 13 days. Twenty-three survivors (96%) required postoperative mechanical ventilation for an average of 6.2 days. Postoperative pulmonary artery catheters were placed in 22 survivors (92%). Hemodynamic modulation with intravenous pressor agents was necessary in 14 (58%). Hemodialysis was required in only two survivors and was not continued after discharge. Extended parenteral or enteral nutritional support was used in 14 patients (58%). A regular diet was achieved by the ninth postoperative day in the majority of survivors.

Follow-up

The current status of all 24 survivors was documented. Seven patients had died since discharge. None of these deaths was related to AAA repair. Five-year survival by life-table method was 67%. There was no five-year survival of the general population matched for age, sex, and race.

The remaining 17 survivors were contacted by telephone from six to 87 months after repair ($\bar{x} = 40$ months). Sixteen patients (94%) were fully ambulatory and only four (24%) reported even mild claudication. No patient experienced open ulcers or rest pain. Only one patient continued to smoke cigarettes, and none have required subsequent vascular operations.

Discussion

Despite the considerable advances made in vascular surgery over the last 30 years, the mortality rate after ruptured AAA remains high. Seven recent series document mortality rates from 15% to 65% after ruptured AAA.[2-8] We report an overall hospital mortality rate of 66%, and 53% over the most recent five-year period.

Several characteristics of our patient population may explain the higher death rate reported in this series. The average age of our patients was 72 years, older than in most other series. Only ruptured AAAs were included in our series. Symptomatic, but intact, aneurysms are often included in other reviews, thus skewing results. Our referral area is primarily rural and transport times are often long. As a result, the number of patients arriving in shock was greater. Finally, we have employed a very aggressive approach to the elective repair of AAA. Only the highest risk patients are turned down. In recent years a greater proportion of the patients with ruptured AAA came from this high-risk group.

Factors most predictive of death after ruptured AAA repair in our series were advanced age, prolonged hypotension, and oliguria. Other

authors have identified specific factors predictive of the outcome.

Wakefield and associates outlined eight preoperative and seven intraoperative predictors of mortality.[8] These factors included a history of heart disease, the extent of shock, renal failure, prolonged operative time, and the amount of blood lost.

Hoffman et al stressed the importance of correct initial diagnosis, extent of hematoma, and history of pre-existing heart disease.[7]

Lawrie and coauthors emphasized the value of early referral, early diagnosis, prompt operation, and the avoidance of technical problems.[4]

Hiatt and associates detailed the errors which led to 29 deaths after ruptured AAA.[5] The most common errors were failure to repair a known AAA electively, delayed diagnosis of rupture, major iatrogenic venous injury, and inappropriate anesthetic technique.

The importance of critical care techniques in the postoperative management of patients after ruptured AAA was well illustrated in our series. In 1981, a policy for the management of ruptured aneurysms was established at our institution. A standard protocol for blood work, type and crossmatch, and intravenous access in the emergency department was instituted. Transfer to a previously notified operating room was performed without further delay. Postoperative ventilation and pulmonary artery cardiac monitoring were applied routinely. Frequent determination of temperature, coagulation profile, arterial blood gasses, cardiac index, and urine output were always obtained. Extended nutritional support was necessary in the majority of the patients. The judicious use of hemodialysis in the early management of acute renal failure was effective. The support of an active blood bank was essential.

As a result of these improvements, the survival rate improved from 25% before 1981 to 47% after 1981. The impact of recent critical care advances on survival after ruptured AAA has also been documented by others.[3,6]

Long-term survival and function of ruptured AAA survivors, however, have not been previously reported. Five-year survival was 67%. This was not different from the expected survival based upon the general population matched for age, sex, and race. Of the 17 remaining survivors, 94% were fully ambulatory. Only four patients (24%) reported mild claudication. No patient has required subsequent vascular reconstruction.

Hollier et al[2] reported long-term survival after 1,112 AAA repairs. Five-year and ten-year survival were 67.5% and 40.7%, respectively. The most common causes of death were heart disease, cancer, and stroke. They concluded that long-term survival after elective AAA repair parallels that of the general population.

The high mortality after ruptured AAA remains high despite advances in vascular surgery and critical care. The long-term survival and function of survivors are excellent. Future improvements in survival will focus upon intelligent, cost-effective screening programs,[11] more specific criteria for following AAA nonoperatively,[12] and successful, elective AAA resection in high-risk individuals.[13]

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Cutting dialysis cost

House Ways and Means Health Subcommittee Chairman Fortney Stark (D-Cal) indicated he will seek to cut the costs of providing kidney dialysis services to 100,000 Medicare beneficiaries. According to Stark, the United States spends about $24,000 each year per dialysis patient, compared to $18,000 per year by Canada for Canadian dialysis patients. Stark claims end-stage renal disease facility operators yield significant profits, noting an East Coast facility administrator who is paid $750,000 per year and his wife, an assistant administrator, who is paid $250,000.■

Whooping cough in a remote area of Mexico

Thomas L. Schlenker, MD
Milwaukee

ABSTRACT. *Over a period of one year, 24 children with demonstrated clinical pertussis (whooping cough) and eight children with suspected pertussis were treated as inpatients at a rural hospital in Mexico. They were studied with respect to clinical characteristics and outcome, total white blood cell count (WBC) with differential, and age. We observed that younger children and those who were growth retarded were more likely to have severe disease. We also found that, in addition to helping confirm the diagnosis of pertussis in patients with classic symptoms, the WBC and differential were invaluable in suggesting the diagnosis in the patients whose symptoms were not classic.*

Key Words: pertussis, rural, children, Mexico, white blood count

FOLLOWING THE INTRODUCTION of the killed whole-cell vaccine in the 1930s, the clinical disease of pertussis had been very nearly eliminated in the United States. During the last decade, however, its incidence has been on the rise,[1] and this increase is likely to continue in the future given that vaccine-induced immunity is not complete. Another factor that may contribute to an increase in pertussis cases is decreased vaccine acceptance due to litigation against its producers and dispensers.[2,3] It is, therefore, advantageous that the practitioner be reacquainted with this "forgotten illness," as Brooksaler and Nelson termed it in the 1960s.[4]

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Methods and patients

This study examined the charts of patients admitted to the pediatric inpatient service of San Carlos Hospital in the town of Alta Mirano, Chiapas, Mexico, between February 1986 and January 1987 and discharged with the diagnosis of pertussis. Consideration was given to the characteristics and outcome of the illness, white blood cell count (WBC) with differential, and age. The author was the principal attending on the pediatric ward for the entire time and personally attended each of the study children.

The patients were primarily pure-blood Mayan Indians of the Tzeltal tribe who lived with their families in small, closely knit villages scattered about the cool Chiapas highlands. Most of the Tzeltales are farmers and animal raisers. Nonetheless, food and potable water are often in short supply. Modern medicine and public health improvements are rarely encountered. Mexico's periodic vaccination campaigns have seldom reached as far as the Tzeltales; only two of our 32 study children had received the pertussis vaccine.

The San Carlos is a 50-bed hospital with 25 pediatric beds located in Alta Mirano, an isolated mountain town of 5,000 inhabitants. The Indians who use the San Carlos are not town dwellers and may have to travel hours or even days to reach the hospital. The hospital laboratory was limited in scope, but it did perform reliable CBCs on a daily basis. Abnormal values followed up with repeat testing showed excellent consistency. Bordetella pertussis cultures and fluorescent antibody smears were beyond the level of expertise for this lab and were not used for this study.

Therapy for pertussis was limited to a good diet with IV fluids as necessary, oxygen by nasal prongs for those who showed signs of hypoxia, and oral erythromycin. Deep suctioning was found to be helpful in some cases, and steroids were used on the more severely affected patients.

Results

Thirty-two children with demonstrated clinical or suspected pertussis were treated as inpatients during the study period. The majority of them looked surprisingly well between coughing episodes and were not dyspneic or otherwise uncomfortable. During the day, they slept or played quietly. Appetites were good.

Ten of the 32 were judged to have severe disease. These children looked ill all the time and were dyspneic even when not coughing. On physical examination, coarse rales could be auscultated over the entire chest, suggesting a generalized pneumonitis. Five children experienced seizures following coughing paroxysms. Two children died. One child, as a result of his cough, developed dramatic scleral and periorbital hemorrhages, a rare but conclusive diagnostic criterion.[8]

Classic pertussis. Twenty-four children exhibited the classic symptoms of a paroxysmal, choking-type cough producing copious mucous and saliva

from the nose and mouth often followed by vomiting. The episodes occurred from five to 30 times a day, lasted about a minute, and ended in varying degrees of cyanosis and exhaustion; post-paroxysmal seizures were not uncommon. Olson[9] described such episodes as "a pitiful sight, all the more so as the observer is helpless to alleviate or terminate the attack." In addition to the severity and frequency of the coughing fits, the prolonged course of the paroxysmal stage of the illness (four to eight weeks) imposed a heavy strain on both patient and family.

All of these 24 cases were diagnosed as definite pertussis according to the clinical and laboratory point system devised by Voorhoeve et al[8,10] and used to great advantage in their large studies carried out in Africa. The average age of these children was 3 years (range, 6 months to 10 years). The mean leukocyte count was 37,394 (range, 19,600 to 138,800). Lymphocytes averaged 69% (range, 42% to 93%).

Suspected pertussis. By definition, none of the children with suspected pertussis showed the classic cough or whoop. Contrary to the usual upper airway focus of the disease, they exhibited persistent generalized lower respiratory tract involvement without fever and unresponsive to IV antibiotics. Each had diffuse inspiratory rales. Three were rather mildly affected, but five were quite severely dyspneic. Noteworthy were heart rates sustained in the 150 to 200 beats per minute range for days at a time in afebrile children.

The diagnosis of pertussis had to be considered in this group because several of them arrived at the hospital with siblings who were concurrently ill with the classic disease. All of these children came from villages where the epidemic was known to be flourishing. Although tuberculosis was endemic to the area, pulmonary TB is not common in young children.

The average age in the suspected pertussis group was 1.2 years (range, 2 months to 2 years). The older ones were invariably growth retarded and malnourished, suggesting that they, along with the younger infants, were either too sick or too small to cough and whoop like the rest. The average leukocyte count was 79,818 (range, 26,250 to 115,500). Lymphocytes averaged 67% (range, 45% to 87%).

Severity of disease correlated with white blood cell count. For the 22 with mild to moderate disease (both groups taken together), the mean leukocyte count was 31,775. For the eight with severe disease, the mean was 46,765. Leukocytes of the two who died averaged 127,150. The two children who died slowly deteriorated over several days with progressive hypoxia marked by extreme tachypnea and sustained heart rates of nearly 200 beats per minute while on oxygen. The most likely cause of death was overwhelming pneumonia secondary to bacterial overgrowth or diffuse mucous plugging of the smaller airways.

Discussion

While classically presenting pertussis may be among the easiest diseases to diagnose, the task is often made difficult by an array of confounders. If the coughing paroxysms occur only five or six times a day, the physician may not be fortunate enough to observe one. Infants, debilitated children, and adults may not exhibit any of the classic symptoms, and while good evidence exists that vaccination protects poorly against acquiring the infection, it certainly does alter the severity and expression of the disease.[11,12] Therefore, the clinician often needs help in diagnosing this disease.

Isolation of the Bordetella pertussis organism is the most definitive proof of diagnosis, but it is a rather insensitive instrument; in most series, it is positive in no more than 50% of cases.[4,13-15] The fluorescent antibody test is both insensitive and of variable specificity.[6,16,17] Both tests are time consuming, expensive, technically difficult, and not universally available.

Conversely, the WBC with differential is quick, cheap, reproducible and ubiquitous. Although an increased white count is nonspecific at lower levels, it becomes more specific as it rises. Voorhoeve considers a white count of 30,000 or more with at least 60% lymphocytes as conclusive evidence for pertussis. Assuming a certain rate of error within that range, the probability of a false positive becomes exceedingly small as the count climbs to 50,000, 80,000 or 100,000 in a child with respiratory illness. Thus, the cost-benefit ratio of the test is quite good.

The sensitivity of the WBC will vary according to the population of

Rheumatic fever resurgence?

The incidence of acute rheumatic fever has plummeted in the United States over the past 50 years. Indeed, many doctors trained within the past two decades have never seen a case of the potentially devastating disease caused by a form of streptococcal bacteria. But an editorial in the Feb 5, 1988, issue of *Journal of the American Medical Association* says a "new, equally surprising and highly disturbing chapter in the epidemiology of rheumatic fever may be in the making." Alan L Bisno, MD, of the University of Miami (Fla) and colleagues cite evidence that rheumatic fever may be making a comeback. They note reports of sizeable clusters of the disease in recent years in the Salt Lake City, Columbus and Akron, Ohio, and Pittsburgh areas, with anecdotal reports of increased numbers of cases elsewhere. The cause for this possible—though still spotty—resurgence is unclear, but the editorial suggests rare or especially virulent bacterial strains may be to blame. It calls for careful disease surveillance, saying doctors "must be aware that the beast is again afoot in the land and must assiduously employ the highly useful diagnostic and therapeutic tools at our disposal to protect our patients from the resurgent spectre of rheumatic fever and rheumatic heart disease."

interest. This study was confined to children who were sick enough to be admitted to the hospital (although our admission criteria were very liberal). Among the group with clinically demonstrated classic pertussis, 22 of 24 had white counts above 20,000 with lymphocyte predominance, a sensitivity of 92%. Other studies using varying cutoff points are in general agreement.[14,17,18] Olson suggests that 70% to 80% of patients will show such a leukocytosis.[9]

The biggest defect in the sensitivity of the white count is that the vaccinated yet infected child will most likely not mount a similar leukocytic response. To what degree it is altered, however, has never been documented in the literature to the author's knowledge. It is also problematical that the leuko/lymphocytosis happens late in the illness making the WBC much less helpful if patients are to be tested during the catarrhal stage.[19]

Another possible sensitivity defect is that young infants may be unable to mount a vigorous leuko/lymphocytosis to the pertussis infection. An especially low number of responders was found by Sotomayer et al[7] in a recent series of infants whose ages averaged 4 months. Our data are quite contradictory to this conclusion. Among our youngest 11 patients (aged 2 months to 1 year) drawn from both the classic and suspected pertussis groups, the mean WBC was 54,414 with 66% lymphocytes. The youngest patient, a 2-month old, had 52,150 white cells with 65% lymphs.

The difficulty of diagnosing pertussis in any child who does not present with the classical symptoms and the changing prevalence of this disease within our own society calls for a reexamination of the white blood cell count with differential as a diagnostic tool for various age groups, especially infants.

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CLINICAL CANCER: Number 25 of a series

Clinical management of lymphomas

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THE LYMPHOMAS COMPRISE a spectrum of malignant disorders that vary markedly in their clinical manifestations, tumor cell biology, and responsiveness to therapy. Because of this heterogeneity, the lymphomas present the hematologist or oncologist with one of the most complex and interesting challenges he or she will meet. Optimal management involves a stepwise approach that proceeds from diagnosis and classification through careful staging to an individualized treatment plan. This paper briefly outlines the basic principles of lymphoma management.

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Diagnosis

The first step in the management of lymphoma is obtaining a biopsy adequate to make a firm diagnosis and to classify the lymphoma. Involved lymph nodes are the preferred biopsy material because histologic patterns tend to be more easily recognized in nodal tissue. Lymphoma infiltrating a non-lymphoid organ such as thyroid can be difficult to classify with certainty. Special studies such as surface marker analysis using monoclonal antibodies to T- and B-cell antigens and immunoperoxidase staining for immunoglobulin light chains or leukocyte common antigen may

assist in recognizing and classifying lymphoma.

Classification

The most important distinction to be made when classifying lymphoma is whether one is dealing with Hodgkin's disease or non-Hodgkin's lymphoma. Staging and treatment strategies will vary substantially depending on this distinction. Hodgkin's disease is usually classified using the Rye system (Table 1). Histologic classification in Hodgkin's disease, however, is much less important than stage of disease in terms of its influence on prognosis and treatment.

Table 1—*Rye classification of Hodgkin's disease*

- Nodular sclerosis
- Lymphocyte predominance
- Mixed cellularity
- Lymphocyte depletion

In contrast, the classification of non-Hodgkin's lymphoma is of paramount importance, and a number of systems have been devised. The two used most widely are the Rappaport system, based solely on histology, and the Working Formulation (Table 2), which considers both histologic features and clinical behavior. The categories of the Rappaport system generally have counterparts in the Working Formulation. Diffuse histiocytic lymphomas, however, must be subdivided before they can be translated into the Working Formulation. The Working Formulation further arranges its histologic types into low-grade, intermediate-grade, and high-grade lymphomas. These groups can be considered pragmatically to indicate favorable, intermediate, and unfavorable prognostic groups, respectively. All of the subtypes of large cell lymphoma, however, are generally considered to carry a poor prognosis.

No classification system yet devised has been universally embraced. The Rappaport system and the Working Formulation have both proved clinically useful in most situations. Both have the deficiency of ignoring immunologic data even though lymphomas with a given histologic appearance may vary in behavior depending on whether they are of B-cell or T-cell origin. Both systems exclude or lump into a miscellaneous group clinically well-defined lymphomas such as mycosis fungoides and the lymphoma associated with HTLV-1 infection.

Staging

Once a lymphoma has been diagnosed and classified, the patient must undergo staging. The Ann Arbor staging system (Table 3) was originally devised for Hodgkin's disease, but is widely applied to both Hodgkin's and non-Hodgkin's lymphomas. It is important to indicate whether a patient's Ann Arbor stage was determined using clinical or anatomic data. The clinical stage is the patient's stage after completion of all blood tests, imaging studies and percutaneous biopsies. The pathologic stage considers, in addition, the results of staging laparotomy.

Staging procedures should be done purposefully. The goals of staging are to assist in the selection of therapy and to establish pretreatment parameters that can be followed during therapy. Because the treatment of Hodgkin's disease varies markedly depending on stage, the approach to staging is generally more aggressive here than with non-Hodgkin's lymphoma. Patients with Hodgkin's disease are initially evaluated with a chest roentgenogram, abdominal CT scan or lymphangiogram, and bilateral iliac crest bone marrow biopsies. In selected patients, additional studies such as gallium scanning or percutaneous liver biopsy may be helpful. Patients who are at stage I or IIA after completion of initial studies and who do not have bulky mediastinal disease are candidates for staging laparotomy in most institutions. This operation involves splenectomy, aggressive abdominal lymph node sampling, open liver biopsy and wedge biopsy of anterior iliac crest bone marrow. The results of laparotomy will increase the final pathologic state in 25% of patients and decrease the stage in 15%.

Staging in the non-Hodgkin's lymphomas does not usually change therapy, and laparotomy is rarely done. In most situations a chest roentgenogram, abdominal CT scan, and bone marrow biopsies will be sufficient. Patients with histiocytic lymphoma involving bone marrow, undifferentiated lymphoma and lymphoblastic lymphoma, and those with neurologic symptoms, should undergo lumbar puncture.

Treatment

The usual treatment of early-stage Hodgkin's disease (stages I and IIA) is extended-field radiation therapy alone. The patient with a large mediastinal mass, however, is often first treated with chemotherapy to decrease the size of the mass. This permits the use of smaller radiation fields so that the lungs can be better

Table 2—*The working formation for non-Hodgkin's lymphomas**

Low grade
Small lymphocytic (diffuse, lymphocytic well-differentiated)
Small lymphocytic, plasmacytoid
Follicular, small cleaved cell (nodular, lymphocytic poorly-differentiated)
Follicular, mixed small cleaved and large cell (nodular, mixed lymphocytic and histiocytic)
Intermediate grade
Follicular, large cell (nodular, histiocytic)
Diffuse, small cleaved cell (diffuse, lymphocytic poorly-differentiated)
Diffuse, mixed small and large cell (diffuse, mixed lymphocytic and histiocytic)
Diffuse, large cell, cleaved (diffuse, histiocytic)
Diffuse, large cell, non-cleaved (diffuse, histiocytic)
High grade
Large cell, immunoblastic (diffuse, histiocytic)
Lymphoblastic (diffuse, lymphoblastic)
Diffuse, small cell, non-cleaved (diffuse, undifferentiated)

*Rappaport classification counterparts are shown in parentheses.

Table 3—*Ann Arbor staging system for lymphoma*

Stage 1	Single node region
Stage 2	Two or more node regions on same side of diaphragm
Stage 3	Node regions on both sides of diaphragm
Stage 4	Extralymphatic organ involvement Substages: A—without fever, sweats, weight loss B—with fever, sweats, weight loss E—involvement of extranodal tissue by extension of nodal disease S—splenic involvement

shielded. Stages IIB and IIIA can be treated with comparable success with total nodal irradiation or combination chemotherapy. Stages IIIB and IV require chemotherapy.

The treatment of Hodgkin's disease is an area marked by controversy and change. One topic of current interest to investigators is whether the use of involved field radiotherapy plus limited chemotherapy (two to three cycles) can be used in patients with nodal disease only to achieve improved disease-free survival with diminished toxicity. Another area of debate concerns the value of alternating cycles of ABVD (doxorubicin, bleomycin, vinblastine, dacarbazine) with the standard MOPP regimen (mechlorethamine, vincristine, prednisone, procarbazine) or of substituting a hybrid regimen in patients with advanced-stage Hodgkin's disease.

The low-grade non-Hodgkin's lymphomas are disorders that, though incurable, have a favorable prognosis because of their indolent behavior. These lymphomas can frequently be left untreated, sometimes for years. When symptoms develop or organ function is threatened, disease can often be managed satisfactorily with non-aggressive chemotherapy or local irradiation.

The therapy of non-Hodgkin's lymphomas with unfavorable prognosis is an area of intense clinical investigation spurred by the demonstration that most patients in this category who achieve complete remission will remain free of disease long term. Therapy has evolved from the CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone) regimen to a new generation of aggressive regimens that incorporate at least one of three features: high dosage, alternation of non-cross-reactive drug combinations and weekly therapy using myelosuppressive drugs alternating with marrow-sparing drugs. These new regimens have resulted in complete remission rates for selected patients with diffuse large cell lymphoma of about 75% with an overall long-term disease-free survival rate of about 70%. These regimens are clearly more toxic and may not be appropriate for some patients.

The treatment of the intermediate-prognosis lymphomas is a relatively neglected area. Some patients can be rendered free of disease over the long term, but the potential for cure in this group of disorders appears paradoxically to be much less than for poor-prognosis lymphomas. There currently is insufficient evidence on whether the application of new-generation lymphoma regimens can increase cure rates. Most hematologists at present would consider the CHOP regiment or one of its variations to be the standard treatment for these disorders.

A number of experimental approaches to the treatment of lymphoma are undergoing evaluation. These include monoclonal antibody therapy, use of biologic response modifiers, and administration of high-dose chemotherapy followed by autologous bone marrow transplantation. Whether or not any of these modalities comes into standard usage, it can reasonably be expected that all aspects of the management of lymphoma will continue to evolve.

Recommended reading

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Infectious Diarrhea caused by *Escherichia coli* (enterotoxigenic strains), *Campylobacter jejuni, Shigella flexneri,** and *Shigella sonnei** when antibacterial therapy is indicated

*Efficacy for this organism in this organ system was studied in fewer than 10 infections

Appropriate culture and susceptibility tests should be performed before treatment in order to isolate and identify organisms causing infection and to determine their susceptibility to ciprofloxacin. Therapy with Cipro® may be initiated before results of these tests are known; once results become available appropriate therapy should be continued. As with other drugs, some strains of *Pseudomonas aeruginosa* may develop resistance fairly rapidly during treatment with ciprofloxacin. Culture and susceptibility testing performed periodically during therapy will provide information not only on the therapeutic effect of the antimicrobial agent but also on the possible emergence of bacterial resistance.

CONTRAINDICATIONS

A history of hypersensitivity to ciprofloxacin is a contraindication to its use. A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin.

WARNINGS

CIPROFLOXACIN SHOULD NOT BE USED IN CHILDREN OR PREGNANT WOMEN. The oral administration of ciprofloxacin caused lameness in immature dogs. Histopathological examination of the weight-bearing joints of these dogs revealed permanent lesions of the cartilage. Related drugs such as nalidixic acid, cinoxacin, and norfloxacin also produced erosions of cartilage of weight-bearing joints and other signs of arthropathy in immature animals of various species (SEE ANIMAL PHARMACOLOGY SECTION IN FULL PRESCRIBING INFORMATION).

PRECAUTIONS

General

As with other quinolones, ciprofloxacin may cause central nervous system (CNS) stimulation, which may lead to tremor, restlessness, lightheadedness, confusion, and very rarely to hallucinations or convulsive seizures. Therefore, ciprofloxacin should be used with caution in patients with known or suspected CNS disorders, such as severe cerebral arteriosclerosis or epilepsy, or other factors which predispose to seizures (SEE ADVERSE REACTIONS).

Crystals of ciprofloxacin have been observed rarely in the urine of human subjects but more frequently in the urine of laboratory animals. Crystalluria related to ciprofloxacin has been reported only rarely in man, because human urine is usually acidic. Patients receiving ciprofloxacin should be well hydrated, and alkalinity of the urine should be avoided. The recommended daily dose should not be exceeded. Alteration of the dosage regimen is necessary for patients with impairment of renal function (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

Drug Interactions

Concurrent administration of ciprofloxacin with theophylline may lead to elevated plasma concentrations of theophylline and prolongation of its elimination half-life. This may result in increased risk of theophylline-related adverse reactions. If concomitant use cannot be avoided, plasma levels of theophylline should be monitored and dosage adjustments made as appropriate.

Antacids containing magnesium hydroxide or aluminum hydroxide may interfere with the absorption of ciprofloxacin, resulting in serum and urine levels lower than desired; concurrent administration of these agents with ciprofloxacin should be avoided.

Probenecid interferes with the renal tubular secretion of ciprofloxacin and produces an increase in the level of ciprofloxacin in the serum. This should be considered if patients are receiving both drugs concomitantly.

As with other broad-spectrum antibiotics, prolonged use of ciprofloxacin may result in overgrowth of nonsusceptible organisms. Repeated evaluation of the patient's condition and microbial susceptibility testing is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Information for Patients

Patients should be advised that ciprofloxacin may be taken with or without meals. The preferred time of dosing is two hours after a meal. Patients should also be advised to drink fluids liberally and not take antacids containing magnesium or aluminum concomitantly or within two hours after dosing. Ciprofloxacin may cause dizziness or lightheadedness; therefore patients should know how they react to this drug before they operate an automobile or machinery or engage in activities requiring mental alertness or coordination.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Eight *in vitro* mutagenicity tests have been conducted with ciprofloxacin and the test results are listed below:

- Salmonella/Microsome Test (Negative)
- *E. coli* DNA Repair Assay (Negative)
- Mouse Lymphoma Cell Forward Mutation Assay (Positive)
- Chinese Hamster V_{79} Cell HGPRT Test (Negative)
- Syrian Hamster Embryo Cell Transformation Assay (Negative)
- *Saccharomyces cerevisiae* Point Mutation Assay (Negative)
- *Saccharomyces cerevisiae* Mitotic Crossover and Gene Conversion Assay (Negative)
- Rat Hepatocyte DNA Repair Assay (Positive)

Thus, two of the eight tests were positive, but the following three *in vivo* test systems gave negative results:

- Rat Hepatocyte DNA Repair Assay
- Micronucleus Test (Mice)
- Dominant Lethal Test (Mice)

Long-term carcinogenicity studies in animals have not yet been completed.

Pregnancy – Pregnancy Category C

Reproduction studies have been performed in rats and mice at doses up to six times the usual daily human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ciprofloxacin. In rabbits, as with most antimicrobial agents, ciprofloxacin (30 and 100 mg/kg orally) produced gastrointestinal disturbances resulting in maternal weight loss and an increased incidence of abortion. No teratogenicity was observed at either dose. After intravenous administration, at doses up to 20 mg/kg, no maternal toxicity was produced, and no embryotoxicity or teratogenicity was observed. There are, however, no adequate and well-controlled studies in pregnant women. SINCE CIPROFLOXACIN, LIKE OTHER DRUGS IN ITS CLASS, CAUSES ARTHROPATHY IN IMMATURE ANIMALS, IT SHOULD NOT BE USED IN PREGNANT WOMEN (SEE WARNINGS).

Nursing Mothers

It is not known whether ciprofloxacin is excreted in human milk, however, it is known that ciprofloxacin is excreted in the milk of lactating rats and that other drugs of this class are excreted in human milk. Because of this, and because of the potential for serious adverse reactions from ciprofloxacin in nursing infants, a decision should be made to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use

Ciprofloxacin should not be used in children because it causes arthropathy in immature animals (SEE WARNINGS).

ADVERSE REACTIONS

Ciprofloxacin is generally well tolerated. During clinical investigation, 2,799 patients received 2,868 courses of the drug. Adverse events that were considered likely to be drug related occurred in 7.3% of courses, possibly related in 9.2%, and remotely related in 3.0%. Ciprofloxacin was discontinued because of an adverse event in 3.5% of courses, primarily involving the gastrointestinal system (1.5%), skin (0.6%), and central nervous system (0.4%).

The most frequently reported events, drug related or not, were nausea (5.2%), diarrhea (2.3%), vomiting (2.0%), abdominal pain/discomfort (1.7%), headache (1.2%), restlessness (1.1%), and rash (1.1%).

Additional events that occurred in less than 1% of ciprofloxacin courses are listed below. Those typical of quinolones are italicized.

GASTROINTESTINAL *(See above),* painful oral mucosa, oral candidiasis, dysphagia, intestinal perforation, gastrointestinal bleeding

CENTRAL NERVOUS SYSTEM *(See above), dizziness, lightheadedness, insomnia, nightmares, hallucinations, manic reaction, irritability,* tremor, *ataxia, convulsive seizures, lethargy, drowsiness, weakness, malaise, anorexia, phobia, depersonalization, depression, paresthesia*

SKIN/HYPERSENSITIVITY *(See above), pruritus, urticaria, photosensitivity, flushing, fever, chills, angioedema, edema of the face, neck, lips, conjunctivae or hands,* cutaneous candidiasis, hyperpigmentation, erythema nodosum

SPECIAL SENSES *blurred vision, disturbed vision, (change in color perception, overbrightness of lights), decreased visual acuity, diplopia, eye pain, tinnitus, bad taste*

MUSCULOSKELETAL *joint or back pain, joint stiffness,* achiness, neck or chest pain, flare-up of gout

RENAL/UROGENITAL *interstitial nephritis, renal failure,* polyuria, urinary retention, urethral bleeding, vaginitis, acidosis

CARDIOVASCULAR palpitations, atrial flutter, ventricular ectopy, syncope, hypertension, angina pectoris, myocardial infarction, cardiopulmonary arrest, cerebral thrombosis

RESPIRATORY epistaxis, laryngeal or pulmonary edema, hiccough, hemoptysis, dyspnea, bronchospasm, pulmonary embolism

Most of these events were described as only mild or moderate in severity, abated soon after the drug was discontinued, and required no treatment.

In several instances, nausea, vomiting, tremor, restlessness, agitation, or palpitations were judged by investigators to be related to elevated plasma levels of theophylline possibly as a result of a drug interaction with ciprofloxacin.

Adverse Laboratory Changes Changes in laboratory parameters listed as adverse events without regard to drug relationship:

Hepatic – Elevations of: ALT (SGPT) (1.9%), AST (SGOT) (1.7%), alkaline phosphatase (0.8%), LDH (0.4%), serum bilirubin (0.3%)

Hematologic – eosinophilia (0.6%), leukopenia (0.4%), decreased blood platelets (0.1%), elevated blood platelets (0.1%), pancytopenia (0.1%)

Renal – Elevations of: Serum creatinine (1.1%), BUN (0.9%)

CRYSTALLURIA, CYLINDRURIA, AND HEMATURIA HAVE BEEN REPORTED.

Other changes occurring in less than 0.1% of courses were: Elevation of serum gammaglutamyl transferase, elevation of serum amylase, reduction in blood glucose, elevated uric acid, decrease in hemoglobin, anemia, bleeding diathesis, increase in blood monocytes, and leukocytosis.

OVERDOSAGE

Information on overdosage in humans is not available. In the event of acute overdosage, the stomach should be emptied by inducing vomiting or by gastric lavage. The patient should be carefully observed and given supportive treatment. Adequate hydration must be maintained. In the event of serious toxic reactions from overdosage, hemodialysis or peritoneal dialysis may aid in the removal of ciprofloxacin from the body, particularly if renal function is compromised.

DOSAGE AND ADMINISTRATION

The usual adult dosage for patients with urinary tract infections is 250 mg every 12 hours. For patients with complicated infections caused by organisms not highly susceptible, 500 mg may be administered every 12 hours.

Respiratory tract infections, skin and skin structure infections, and bone and joint infections may be treated with 500 mg every 12 hours. For more severe or complicated infections, a dosage of 750 mg may be given every 12 hours.

The recommended dosage for infectious diarrhea is 500 mg every 12 hours.

In patients with renal impairment, some modification of dosage is recommended (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

HOW SUPPLIED

Cipro® (ciprofloxacin HCl/Miles) is available as tablets of 250 mg, 500 mg, and 750 mg in bottles of 50, and in Unit-Dose packages of 100 (SEE FULL PRESCRIBING INFORMATION FOR COMPLETE INFORMATION).

*** Due to susceptible strains of indicated pathogens. See indicated organisms in Brief Summary.**

CONVENIENT *B.I.D.* DOSAGE

Recommended dosage schedule

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Respiratory Tract*	Mild/Moderate	500 mg *B.I.D.*
Bone and Joint* Skin/Skin Structure*	Severe/Complicated	750 mg *B.I.D.*
Urinary Tract*	Mild/Moderate	250 mg *B.I.D.*
	Severe/Complicated	500 mg *B.I.D.*
Infectious Diarrhea*	Mild/Moderate/Severe	500 mg *B.I.D.*

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Newborn screening for sickle cell disease and other abnormal hemoglobins

Nasrollah T. Shahidi, MD
Madison

HUMAN RED BLOOD cells normally contain at least three types of hemoglobin. These are designated as Hemoglobin A, A2, and F, and can be readily separated and identified by electrophoresis. Each of these hemoglobins is a tetramer and consists of two pairs of unlike polypeptide chains. These hemoglobin chains, known as alpha, beta, gamma, and delta, are under genetic control.

Hemoglobin A, which is the bulk of the adult hemoglobin (greater than 90% of total), is made of two alpha and two beta chains. Between 2.5% and 3% of the hemoglobin in the normal cell is hemoglobin A2 which contains two alpha and two delta chains.

Hemoglobin F, which is made of two alpha and two gamma, is the main component during human fetal development. After birth, the concentration of fetal hemoglobin declines and is usually below 2% after 36 months. A higher concentration of this hemoglobin beyond this age is indicative of genetic or acquired disturbance in hemoglobin synthesis. Qualitative abnormalities in individual globin chains result in mutant hemoglobins such as sickle cell hemoglobin, whereas quantitative abnormalities in globin chain production give rise to the thalassemia syndromes.

To date, more than 300 structurally different human hemoglobin variants have been discovered. Most of these constitute a single amino acid substitution in one of the globin polypeptide chains. The resulting structural abnormality can produce a variety of pathophysiological disturbances such as abnormal red cell shape (eg target cells and sickle cells), hemolytic anemia, unstable hemoglobin molecule, or an increased affinity for oxygen resulting in erythrocytosis. In addition, structural abnormalities could co-exist with thalassemia syndromes. The most common type of this combination is Hemoglobin S-beta thalassemia.

The frequency of the abnormal hemoglobins varies considerably with geographic location and racial groups. Hemoglobins, S, C, D, Punjab, and E are often called the common hemoglobins because each affects millions of individuals. Hemoglobin S is certainly the most common of all abnormal hemoglobins. The highest incidence occurs in the eastern part of Africa where 40% to 50% of the members of certain tribes are affected. In the United States, the overall prevalence of the S-trait among blacks is about 8%. Sickle cell diseases (SS, SC, S-beta thalassemia) affect about one out of every 400 American black newborns.

Advantages of newborn screening

It has been known for a long time that children with sickle cell anemia have increased susceptibility to severe bacterial infection, particularly due to *Streptococcus pneumoniae*. The risk of major infection with this organism is greatest in the first three years of life and can occur as early as four months. This infection may be the first clinical manifestation of sickle cell disease and carries a fatality rate as high as 30%.

Another catastrophic event that significantly contributes to the mortality in infancy is the acute splenic sequestration crisis. This is one of the leading causes of death in children with sickle cell anemia. Children with sickle cell anemia who have not yet undergone autosplenectomy, as well as older patients with SC disease or S-thalassemia, may have a sudden, massive enlargement of the spleen with the trapping of a considerable portion of the red cell mass. The tempo of this crisis may be so fast that the patient may die before reaching the hospital.

There is now ample evidence demonstrating a reduction in morbidity and mortality through early diagnosis and immediate entry into programs of comprehensive care including penicillin prophylaxis. Screening for hemoglobinopathies in the newborn greatly facilitates early diagnosis and has the capability of reaching infants who might otherwise be lost to the health care system.

Neonatal testing to identify infants with sickle cell disease allows prompt institution of ongoing care, including the provision of effective antibiotic prophylaxis. Indeed, a recent multi-center randomized trial of oral penicillin prophylaxis in children with sickle cell disease

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showed an impressive 85% reduction in the incidence of infection in the group treated with oral penicillin as compared to the group given placebo. Thirteen septic episodes among the 110 patients in the placebo group resulted in three deaths compared with no death and only two septic episodes among the 105 patients treated with prophylactic penicillin.[1] Because babies with sickle cell disease may develop sepsis as young as four months, early provision of comprehensive care combined with prophylactic penicillin prior to the age of four months is generally recommended. The availability of pneumococcal vaccine may be an additional factor contributing to the improved survival.

There are currently ten comprehensive centers for sickle cell disease in the country, which are funded by the National Institutes of Health.[2] Six centers have been participating in a screening program for five to ten years, three centers for 11 to 15 years and one center for 17 years. The most common methods used for screening are cellulose acetate and acid agar gel electrophoresis. Few centers use high pressure liquid chromatography (HPLC) or isoelectric focusing techniques.

As might be anticipated, there are still a number of problem areas with the screening programs. These are difficulties in establishing and maintaining clinical follow-up because of mobility of families, lack of compliance and participation by some families, and difficulties in tracking individuals with sickle cell trait for counseling. It is clear that the health risks to children with sickle cell disease are so great that major efforts should be made to identify every affected child, through a compulsory statewide screening program.

Counseling and follow up

When a newborn infant with hemoglobinopathy is identified, the health care provider must contact the family with the results of the screening and offer family testing, counseling or referral. It is obvious that providing such information could be disruptive to the well-being of the family. Discrimination in employment and insurance, fears of chronic illness, disclosure of non-paternity and concern about sickle cell disease in future pregnancies are examples of possible problems. Therefore, the health care provider must approach and counsel the family judiciously.

The disclosure of non-paternity will undoubtedly have a negative impact on family relationships, particularly when the child has a chronic illness. Impaired relationships with the child might extend over a lifetime.

Unless absolutely essential for the management of the child or for providing reproductive counseling, the parents need not be tested when the child has sickle cell disease. In most instances the diagnosis is clear and the parents can be told which genes they collectively have, and the service providers do not need to know which parent carries which gene. Obviously, if the parents request testing, it should be performed. If a newborn has one of the hemoglobinopathy traits, the mother should be tested for the purpose of reproductive counseling. If the mother does not have the trait in question, she can be told that the father does, which is the case. There is no need for the service providers to confirm this by testing the alleged father. On the other hand, if the mother has the trait the father can be then tested with impunity, for a source of the child's genes has been identified.

Every child affected by a clinically significant hemoglobinopathy should receive comprehensive specialized care regardless of social or economic status. Ideally, sickle cell treatment centers should have staff and support services to care for the medical and psychological needs of sickle cell patients and their families. This model, however, may not be available in all areas. A multidisciplinary approach and 24-hour availability of care must be a part of any sickle-cell care program. The health provider responsible for the longitudinal follow-up of the child with sickle cell disease must be prepared to: 1. determine the exact nature of sickle cell disease (SS, SC, S-Thal, etc); 2. counsel the parents about the risk of having future children with the trait or disease, or refer the patient for such genetic counseling; 3. start penicillin prophylaxis prior to age 4 months, and make every effort to assure compliance; 4. institute routine immunization as well as *Haemophilus influenza* type B vaccine at 18 months and 2 years and *Streptococcus pneumoniae* vaccine at 2 years; 5. emphasize the importance of adequate fluid intake particularly during diarrheal episodes; and 6. inform the parents about the clinical manifestations and particularly emphasize the symptoms and urgency of the care in splenic sequestration crisis.

Training and continuing education of professional providers is of paramount importance and must be regularly included within the curricula of medical schools, nursing schools, social work, and other appropriate professions as well as in continuing post-graduate courses. Such an education should provide the students and professionals with knowledge in the etiology, pathophysiology, treatment and counseling.

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An abbreviated caution

Doctors often write "OD" on prescriptions to indicate a drug is to be taken "once daily," but it can also be interpreted to mean "one dose" or "every day" (from the Latin omni die). It might also mean "on demand" or "one drop" at a time. One physician prescribed a several-day supply of pills for a patient to be filled OD—"on departure"—but a nurse told the patient the pills were to be taken in "one dose." The patient wound up in an emergency room with a "drug OD."—*AMA Briefs*■

Why medical students become medical students

Sigurd E. Siverston, MD, Madison

DURING THEIR DEAN'S letter interview, 304 medical students graduating in 1986 and 1987 were asked when they first decided to become physicians and what influences led them to the decision. This is a report of their answers.

Their answers to the question of *when* were: in high school, 22%; in childhood, 20%; in college, 20%; and after college, 5.3%. Fully 33% could not answer the question within the 30-minute interview.

Their answers to the question of *influences* were: an early interest in science and helping people, 36.5%; work experience in a health-related field, 19%; their home doctor, 11%; a high school or college counselor, 4.3%; a personal illness, 4.3%; a missionary background, 2.6%; miscellaneous, 2.6%; and the death of a friend or relative, 2%. For some, the decision to become a physician was influenced by the broader context of their lives: 9.5% switched to medicine from another health field, 5.6% changed from employment in research, and 0.7% shifted from work on a PhD.

Family backgrounds played a significant role in influencing these students: 17.4% had a physician father, 7.2% had a nurse parent, 3.6% a physician sibling, 3.6% a physician grandfather, 1.9% a physician uncle, 1.6% a pharmacist parent, and 0.3% had a dentist, occupational therapist or hospital administrator parent, or a physician mother.

It was surprising that 20% of the students aspired to a medical career in childhood. Their answers were quick and confident compared to those of the students in the high school or college categories. They expressed it as: "I knew when I was 6 or 7 years old that I wanted to become a doctor," "I remember trying to help an injured animal, and that started it," "My home doctor made me feel like I was his only patient, and people respected him so." For these students, the aspiration seemed to grow out of an early experience of helping life.

High school and college years were pivotal in the lives of 42% of the students. Scholastic excellence, particularly in biology and science, led to a crossroad—"What will I do with the rest of my life?" They decided to use their scholastic excellence to help people, and they thought medicine offered the best opportunity.

Family influences were important to about 40%. Contrary to a common view, only 17% had a physician father. Other physician members of the family were brother, sister, grandfather, uncle, and mother. Family members serving in other health professions, such as nursing, pharmacy, dentistry, and hospital administration, were noted by about 10% of the students. On the other hand, a large majority (63%) cited no family member involved in health professions. For them, aspirations to a medical career came from outside the family.

Of the influences outside the family, work and volunteer experience in a health care setting—such as nursing homes, emergency rooms, children's camps, and hospitals—was significant. Some students learned they did not like working in non-health-related occupations. The family physician influenced about 11% of the students. Based on this sample, about 1,600 of the nearly 16,000 students entering medical school each year are there because of a home physician's influence. Not infrequently, a career started in another health field lacked the lifetime challenge a student was seeking. Students who considered themselves incapable of a career in medicine were often encouraged by counselors, parents, and friends who recognized their potential. Personal illnesses or the deaths of friends or family influenced some, and missionary backgrounds others.

Thirty years ago, there was a dramatic drop in the number of applicants to medical schools. Surveys of premedical students then tried to determine why.[1] Applications rose to new highs in the 1970s, but fell again in the 1980s. This year, the American Association of Medical Colleges (AAMC) reported the results of a survey to find explanations.[2] These two surveys have similar findings: high costs, long time commitments, tough admission requirements, the greater appeal of other careers, poor physician image, etc.

The AAMC findings, however, contain two disturbingly different reasons: discouragement by practicing physicians and impairment of physician independence by changes in the health care system. These bring into question the inspirational

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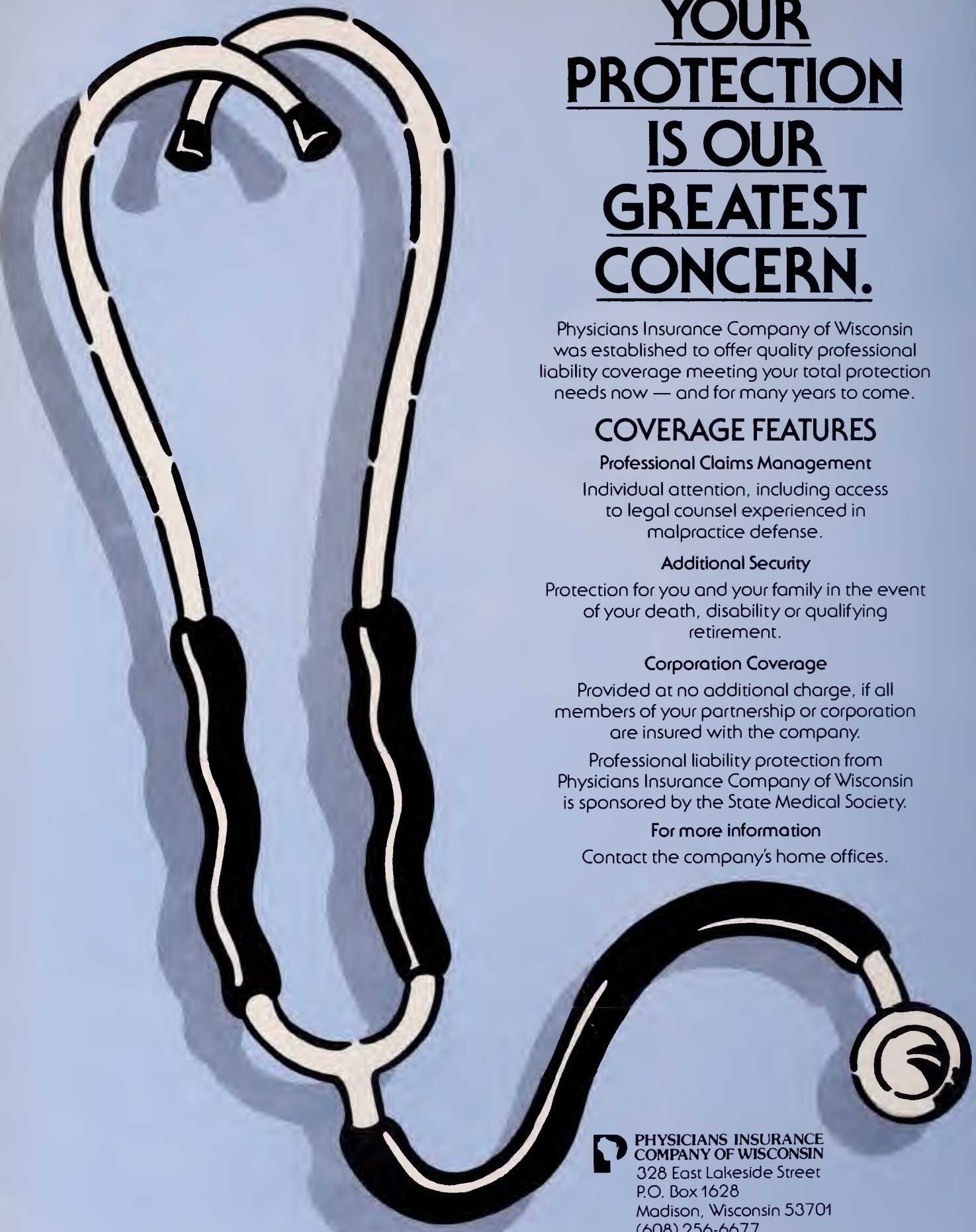

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role of home physicians for students now considering a medical career. Whether these negative factors will seriously blunt the altruism expressed by the recent graduates in this study remains to be seen.

Recruitment of future medical candidates may become intense. To be successful, recruiting strategies must take into account both the positive and the negative factors influencing students' decisions on whether to enter the medical profession.

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SOUNDINGS

Apologetic medicine

Donald P. Hay, MD, Milwaukee

With the advances in medical technology physicians have developed the ability to provide a level of care that is surpassing all expectations—but, paradoxically and almost correspondingly, the respect for physicians has plummeted. Until recently, physicians had little to offer to their patients other than comfort and compassion. For this they were treated with warm admiration. Respected and honored for many years, physicians have over the past few years become targeted by society as fallen angels.

Why has this situation developed, and in such a relatively short period of time? For one, decreased personal attention (especially of the home visit) and increased technological demands have led to our functioning more as scientific technicians than as personal and family ombudsmen. A significant increase in public awareness of medical practice has helped to demystify the physician and, as such, is a positive development. But with the removal of the mystery of medicine has come the debasing of its practitioners. Should the outcome of our ministrations be anything but perfect we are accused of malpractice. We are viewed as perpetrators of crimes rather than healers of the sick. Public advocacy groups and attorneys openly advertise to the public to rally a defense against the evil practitioners of medicine. The climate is ripe in our society to attack those who have traditionally been viewed as powerful and beyond reproach. As physicians we have come to apologize for our role in society.

The pendulum has come full swing, from awe and reverence to suspicion and condemnation. The pendulum will no doubt swing back from this position but, we hope, before too much damage is wrought. I would make a plea for the pendulum to come back halfway. Not fully back to a position of physicians being over-revered, and not to stay where it is now with physicians as targets of anger and rage—but halfway back, where physicians are neither revered nor despised but recognized as caring practitioners of medical science.

Dr Hay is an associate clinical professor at the Medical College of Wisconsin and the University of Wisconsin Medical School, and president elect of the Wisconsin Psychiatric Association. Reprint requests to: Donald P. Hay, MD, Columbia Hospital Medical Arts Building, Suite 302, 2015 E Newport Ave, Milwaukee, WI 53211 (phone: 414-964-9013). Copyright 1988 by the State Medical Society of Wisconsin.

Anal/genital warts and HIV infection

Anal/genital warts do not appear to be a risk factor for human immunodeficiency virus (HIV) infection but do seem to serve as markers for infection, according to a letter in the December 27, 1987 issue of the *Journal of the American Medical Association.* Charlotte Kent and colleagues at the University of California, Berkeley, base their conclusions on a review of data from the San Francisco Men's Health Study, a prospective HIV/AIDS study involving more than 1,000 men aged 25 to 54 years. This review revealed an association between HIV infection and a history of anal/genital warts. However, a further comparison of 30 HIV-positive men in the San Francisco study and 300 HIV-negative matched controls found no difference between the two groups with respect to a history of warts. A comparison of HIV-positive individuals and AIDS patients also showed no significant difference in incidence of anal/genital warts.—***AMA Brief Report***■

WRITING CONTEST

First annual *WMJ* writing contest awards

The winners of the first annual *Wisconsin Medical Journal* writing contest were Lance P. Longo (medical student category) and Gwen D. Martin, MD, (resident category). Longo and Dr Martin were presented their awards and checks for $500 by Richard D. Sautter, MD, medical editor of the *WMJ* at the 1988 SMS Annual Meeting in April.

Longo is a third-year medical student at the Medical College of Wisconsin, and Dr Martin is a second-year surgical resident at the Gundersen Clinic in La Crosse. Their winning papers are presented on the following pages. Rules for entering the 1989 contest are listed below.■

Dr Sautter (l) congratulates Lance Longo (r)

Dr Sautter (l), Dr Martin (c) and Dr Overholt (r)

WMJ Writing contest rules

Contestants
- medical students enrolled in either of Wisconsin's medical schools.
- residents actively training in Wisconsin

Awards
- one student; one resident
- recognition certificate and $500
- publication of paper in the *Wisconsin Medical Journal*
- presentation at the 1989 SMS Annual Meeting

Rules
- subject matter must fall within the parameters of scientific medicine: clinical, case report, research and review
- paper must be original, unpublished, and credited to one author (although multiple authors may be listed)
- limited to 10 pages, typewritten, double-spaced, 1-inch margins
- illustrations are encouraged, but must be included in the 10-page length limit
- the Editorial Board of the *Wisconsin Medical Journal* serves as the panel of judges and has final authority

Criteria
- *scientific merit:* research methods, data analysis, subject or patient population selection, control of variables, literature analysis
- *applicability:* usefulness of results to private practitioner, academician, researcher
- *content:* depth of analysis, continuity of discussion supporting the main thesis, feasibility of conclusions
- *innovation:* uniqueness of idea, creativity, improvement of existing techniques, previously undiscovered data, advancement of basic understanding
- organization and clarity of writing

Deadline
- Entries must be received by the *Wisconsin Medical Journal* no later than Jan 31, 1989: PO Box 1109, Madison, WI 53701.■

Medicine on television: fact, fiction, or both?

Lance P. Longo, medical student
Medical College of Wisconsin, Milwaukee

ABSTRACT. *This study examined the accuracy of television's portrayal of medicine and physicians. Results indicate that, although physicians on television are currently depicted with more behavioral variance than in the past, television's representation of specific illnesses and treatment modalities is usually accurate and realistic. Implications for improving the doctor-patient relationship are discussed, and the discussion takes into account the patient's television-generated expectations of health care.*

Key words: medical media, television, communications

MEDICINE, with its potential for suspense and drama, is ideally suited for depiction on television. Network researchers agree that the identifiability of life-or-death situations has proven to be TV's most powerful audience attractor.[1] Studies of daytime serials, which attract 70 million viewers daily, report that health is the most frequent topic of conversation and that the hospital or doctor's office is second only to the living room as the most frequently used setting.[2] In fact, the 1982 surgeon general's ten-year study on television and behavior concludes that television may well be the single most common and pervasive source of health information today.[3]

Lance P. Longo is a third-year medical student at the Medical College of Wisconsin. This study was funded by the National Fund for Medical Education through a SmithKline Beckman Medical Perspectives Fellowship. Reprint requests to: Lance P. Longo, 2968 N Oakland Ave #4, Milwaukee, WI 53211 (phone: 414-332-1807). Copyright 1988 by the State Medical Society of Wisconsin.

But is the depiction of medicine as portrayed within the entertainment framework of television accurate? How do networks insure the veracity of TV doctor shows? Why do a vast majority of physicians feel that television is negligent in its ethical obligation to realistically portray the practice of medicine? Does television really influence society's perceptions of health care?

This paper reports the findings of a study which investigated the degree to which the portrayal of health care on television is based on fact, fiction, or a bit of both.

Methods

Four sources of data were used to examine the portrayal of medicine on television.

1. Previously published television research and literature relating to the portrayal of medicine on TV was reviewed. Literature included the 1982 surgeon general's study on television and behavior, the work of George Gerbner and his colleagues at the Attenberg School of Communication, and articles from medical and communications journals.

2. A video analysis was conducted to document cases of medical treatment and their outcomes, decision-making processes, and personality traits of characters for 35 recorded episodes of TV doctor shows aired during the 1986 season. ("St Elsewhere," "Trapper John, MD," "General Hospital," and "Kay O'Brien, MD.")

3. Personal interviews with network researchers, production personnel, script writers, and medical consultants were conducted. These interviews included visits to the sets of NBC's "St Elsewhere" and ABC's "General Hospital" in their Los Angeles studios.

4. A random sample of physicians belonging to the Medical Society of Milwaukee County was surveyed (500 questionnaires sent; 184 respondents). The survey assessed physicians' television viewing experience for six preselected past or present TV doctor shows. Perceptions of the veracity of television's depiction of the doctor-patient relationship, medical treatment modalities, and behavioral characteristics were assessed in the survey.

An historical perspective

Medicine is the most frequently represented profession on television. Historically, physicians have been portrayed more favorably than all other professionals.[4] A frequently cited study by McLaughlin concluded that: "doctors on television symbolize power, authority, and knowledge, and possess the almost uncanny ability to dominate and control the lives of others. Their power extends not only to medical practice but also into the private lives of their patients."[5] Indeed, in McLaughlin's sample of TV doctor shows, tallied outcomes of a doctor's medical treatments were successful in 44% of the cases and ambiguous in 36%, but involved resolution of a personal or emotional crisis in 100%! Other investigators report that 61% of prime time TV doctors' work was done on house calls or in the field.[6] But the image of the physician as personified by Marcus Welby's routine of house calls, hugs, and happy end-

ings is changing. Beginning with "M*A*S*H," and continuing with "St Elsewhere," a new multi-dimensional and often more fallible (human?) depiction of physicians is being presented. Turow notes that this broadened portrayal of the physician is paralleled by the increasing attention spent on current medical problems like drug and alcohol abuse, AIDS, and the social and emotional implications of terminal illness.[7]

Perennial Emmy Award winner "St Elsewhere," considered by many physicians to be the most medically accurate and detailed TV medical program,[8] illustrates this transition. The basic philosophy of "St Elsewhere" is to create very human stories about people relating to other people—the people happen to be doctors, nurses, and patients. Medicine and the hospital setting provide texture to the interactions between people.[9]

According to Paul Fontana, assistant to the writers of the show, the target audience of females and young, upwardly mobile professionals combined with unusually low Nielsen ratings (42 among prime time programs for the fall 1987 season)[10] allows "St Elsewhere" more lenience from network censors. Topics ranging from physician drug abuse to sexual promiscuity, testicular cancer, prosthetic penile implants, and sperm bank donations illustrate the liberalization of network censorship standards. Fontana emphasizes that "although realism is important, so is keeping up to date with current issues, treatments, and ethical dilemmas of medicine." Interestingly, as Edwards observed, while the doctors on "St Elsewhere" are human, and their patients do occasionally die, this may be one reason that the show has not done well in the ratings. Television viewers want happy endings which, realistically, medicine can't always provide.[11]

How physicians feel about their media depiction

Although self-reported viewing frequencies indicate that physicians as a group watch substantially less TV than the general population, an overwhelming majority (86%) of the physicians responding to our survey believe that television inaccurately portrays the practice of medicine.[8] The majority of our responding physicians also believe that television has an ethical obligation to accurately portray both the practice of medicine and the high levels of professional behavior expected of physicians to viewing audiences.

A response which typifies this perspective was provided by a senior physician: "I do expect the media to be accurate technically, to avoid scenes of violence, and to avoid an unfairly biased presentation of the medical profession. . . . Entertainment should be entertaining and draw from human experience—but certain attempts to overly dramatize an individual's virtues or failings tend to create unrealistic expectations, or worse, to denigrate the entire profession. Otherwise, who can blame TV for using this most fascinating world of medicine!"

The network response

NBC network executives interviewed as part of this study agreed that, aside from news programming, the goal of TV is to entertain, not to document reality or to educate. Horst Stipp, director of research for NBC, said, "Individual character development is the responsibility of the writer, the actor, and the make-up man—whose obligations lie first and foremost with giving the viewer what they want to see.

"Dramatic sensationalization, the creation of a heightened level of suspense, interest, and conflict are necessary because that's what today's audiences demand," Stipp said. "If people wanted to watch reality, they would just sit and look out the window all day." (Indeed, if medicine were portrayed in all its grandure—complete with routine lab tests, insurance forms, and bedpans—would anyone watch?)

William Rubens, vice president of research for NBC, said, "Television reflects society—and doctors are no different than other people in society. There are some you'd like to be friendly with and others you wouldn't like to be friendly with." Rubens chuckled, and then added, "I'm not sure anybody ever believed Marcus Welby was for real—I think he was perceived accurately as a fictional Dr Goodshoes."

Network personnel, as exemplified by both Stipp and Rubens, adamantly assert that television does not influence a viewer's perception of reality. The television industry assumes that viewers can differentiate fantasy from reality.

Many researchers who study the impact of TV on viewers, including George Gerbner and his colleagues at the Attenberg School of Communication at the University of Pennsylvania, disagree with the industry's views. They have concluded that television does in fact play a major role in reality orientation for people of all societies, especially for those who are heavy viewers and do not often come into direct contact with the particular institution presented (ie, health care).[12] This opinion is shared by 63% of our surveyed physicians, who said they believe that television is influencing their patients' perceptions of them as physicians.

While there is disagreement over the representation of behavioral traits of characters portrayed as physicians on TV, the networks and our physician respondents agree on the importance of accurately depicting the technical aspects of medicine. Rubens emphasized that the accuracy of the portrayal of individual diseases and their treatments on TV medical shows is critical to the credibility of the program—and, indeed, all of the networks maintain medical consultants to ensure that accuracy.

The medical advisors for "St Elsewhere," Dr Nancy Good, a California internist, and Barbara Krause, a licensed critical care nurse, play integral roles in assuring the medical accuracy of the program. To give the program's human interest philosophy its medical texture, Dr Good is called upon during the writing of scripts to choose diseases and treatments consistent with the particular emotions and situations of each story line and to supply the medical dialogue. Krause is the show's technical advisor, whose responsibilities are to make the set as realistic as possible and to coach the actors on the finer

points of handling patients and performing medical procedures.

Content analysis

The results of a content review of 35 episodes of TV doctor shows (involving 71 cases of medical treatment) aired during the 1986 season are consistent with the views of media researchers and our physician survey respondents, as reported in previous sections.

First, television does not always depict the real world of medicine. On television, the setting for medicine is almost exclusively hospital-based and in most cases involves the treatment of traumatic injuries via emergency room admissions. In contrast, a national study of the most frequently rendered diagnoses by physicians cites hypertension, normal pregnancy, and general medical exams as the most common conditions requiring medical attention (see Table).[13] In addition, the content analysis shows that TV doctors not only cure 56% of their patients' medical problems, but resolve 81% of their emotional problems as well. Furthermore, 86% of the time, TV physicians pursue the case into the private life of the patient or disobey a set rule, precedent, convention, or legality to perform a treatment.

The second major finding from the content analysis relates to the accuracy of the depiction of medical procedures on TV. Although cases of medical treatment are often sensationalized on television (eight of nine pregnancies involved life-threatening complications), the selected treatments for specific illnesses are generally accurate and medical hierarchy and authority are maintained.

Third, today's TV doctors are depicted more multi-dimensionally than they have been in the past. This greater range of behavioral characteristics, however, rarely interferes with their professional competence.

Conclusions

Few other inventions have so completely enveloped an entire population as has television. Americans spend more time watching television than doing anything else except sleeping.[6] Its prevalence gives it an implicit manipulative quality—an interpretive framework through which definitions of reality and behavioral norms are initiated, developed, and cultivated.

The five most common illnesses and injuries treated in the US

Physician survey	*TV Content analysis*	*National study*[13]
1. hypertension	1. car accident injuries	1. hypertension
2. URIs	2. pregnancy with complications	2. normal pregnancy
3. arthritis	3. trauma (blunt)	3. general medical examination
4. low back pain	4. gunshot wounds	4. URIs
5. diabetes	5. psychiatric	5. sprains and strains

Media researchers and physicians concur that television provides a substantial portion of medical orientation for a large number of people in our society. This synthetic orientation often leads to the formation of preconceived expectations of real-life health care. Physicians have been subjected to the stresses of their media portrayal from both ends of the spectrum. The historical Marcus Welby model of the medical doctor created standards for real-life physicians that are difficult and sometimes impossible to attain. His patients did not die, he made house calls, and he always had that most precious and rare real-life entity—time. Welby's unrealistic depiction of the medical doctor makes the new, more fallible image of today's physician appear all the more negative. On the other hand, considering that real-life physicians encounter personal crises at rates that often supercede those of the general population—alcohol and drug abuse, divorce, and suicide to name a few—a more varied television personification may be in order.

We live in an era in which society in general is more suspicious of all institutions—whether it be the government, the media, or the health care system. Members of a profession constantly subjected to the public's scrutiny have a responsibility to be aware of their portrayal in the mass media. Awareness of one's image allows for a more thorough understanding of patient concerns and behaviors, and the bridging of important communicative gaps in the very cornerstone of health care—the doctor-patient relationship. Misconceptions can be clarified, expectations realistically identified, and fears confronted if physicians take the time to see themselves through their patients' eyes. Physicians have an obligation to watch enough TV to understand the facts and fiction of TV medicine.

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Peritoneovenous shunting for malignant ascites

Gwen D. Martin, MD, and *Thomas H. Cogbill, MD,* La Crosse

ABSTRACT. *Peritoneovenous shunts were placed in 21 patients with intractable malignant ascites during a four-year period. Patients ranged in age from 41 to 81 years ($\bar{x}$ = 64.3 years). The most frequent malignancies in this group were metastatic gastric (three patients), colorectal (three), liver (three), and ovarian (two). Twenty-five shunting procedures, including three revisions and one shunt removal, were performed. The LeVeen shunt was implanted in 20 patients (95%). Hospital stay ranged from five to 31 days.*

Mean immediate weight loss was 3.7 kg. Symptomatic palliation with improvement in quality of life was evident in 15 patients (71%). Six patients died during the initial hospitalization, but there were no shunt-related deaths. Most frequent complications were hypokalemia (ten), hemodilution (ten), thrombocytopenia (four), and shunt occlusion (four). Shunt-related coagulopathy did not occur in any patient.

Mean survival after shunt placement was 81.6 days. At the time of our study, four patients were alive at 25, 169, 177, and 233 days after the procedure. Mortality was related to progression of the malignant disease and not peritoneovenous shunting. Symptomatic relief from intractable malignant ascites can be safely achieved by placement of a peritoneovenous shunt.

Key **Words:** malignant ascites, disseminated carcinoma, peritoneovenous shunt, LeVeen shunt.

MALIGNANT ASCITES may become progressively incapacitating for patients with terminal stages of carcinoma. Clinical symptoms including dyspnea, anorexia, nausea, and abdominal distention may be unresponsive to medical management. Initially used for decompression of cirrhotic ascites, peritoneovenous shunts in recent years have been placed to relieve intractable symptoms secondary to malignant ascites.

In 1962, Smith described the first peritoneovenous shunt.[1] A one-way compressible Holter valve was used to drain the ascites from an abdominal catheter into the inferior vena cava. LeVeen introduced a peritoneovenous shunt in 1974 with a self-closing one-way valve that depended on the pressure gradient between the abdominal cavity and the central intrathoracic veins for removing the ascitic fluid.[2] Several studies have shown successful palliation with the shunt.[3-5] We reviewed our recent experience with peritoneovenous shunting for malignant ascites to better define the indications, complications, and long-term results.

Materials and methods

During the four-year period ending August 1987, peritoneovenous shunts were placed in 21 patients with refractory malignant ascites. We reviewed patient charts for indications, symptoms, complications, pertinent laboratory data, and outpatient follow-up. The patients had tense ascites unresponsive to standard medical treatment. Symptomatic ascites was evident clinically by dyspnea, anorexia, nausea, abdominal distention, fatigue, and inability to walk. The primary tumor was identified in each patient.

The operative technique used was similar to that described by LeVeen.[6] General anesthesia was used for initial placement. Subsequent revision or removal was done with local anesthesia. A transverse upper abdominal incision was made and the muscle incised to the peritoneum. A purse string suture was placed in the peritoneum and the silastic catheter with multiple small openings was inserted into the abdominal cavity. The valve was placed just beneath the anterior rectus sheath. The venous portion was tunnelled through the subcutaneous tissue of the chest wall to the neck where the internal jugular vein was exposed. A venotomy was made and the catheter placed with the tip lying within the superior vena cava. Postoperatively, diuretics were administered to enhance urine output, and, if necessary, an abdominal binder was applied to improve egress of ascitic fluid.

Results

Our study included ten women and 11 men whose ages ranged from 41 to 81 years ($\bar{x}$ = 64). Twenty-five shunting procedures were performed, including three revisions and one removal. LeVeen shunts were placed in all patients with the exception of one patient who had a Denver shunt.

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The primary tumors are listed in Table 1. The most frequent tumors were gastrointestinal, hepatocellular, and ovarian malignancies.

Patients were hospitalized from five to 31 days ($\bar{x} = 16$). Postoperatively, mean urine output for the group in the first 24 hours was 2164.0 ml and mean weight loss at 72 hours was 3.7 kg. Fifteen patients (71%) had either objective or subjective palliation of their symptoms. Six patients died during the initial hospitalization. Thirty-day mortality was 38%, but no death was attributable to the shunt alone.

The most frequent complications, which are listed in Table 2, were hypokalemia, hemodilution, thrombocytopenia, and shunt occlusion. Three patients did have minimal elevations of their coagulation profiles. No patient, however, demonstrated clinical evidence of bleeding. The majority of complications occurred in the six patients who died during the initial hospitalization.

Patient survival ranged from seven to 233 days ($\bar{x} = 81.6$ days) as shown in the Figure. At the time of our study, four patients were still alive at 25, 169, 177 and 233 days after the procedure, with three maintaining adequately functioning shunts. The fourth patient was determined by shuntogram to have multiple loculations contributing to a nonfunctioning shunt.

Table 1—*Site of primary carcinoma in 21 patients with malignant ascites*

Gastrointestinal	6
Hepatocellular	3
Ovarian	2
Breast	1
Renal	1
Other	8

Table 2—*Complications after peritoneovenous shunting in 21 patients with malignant ascites*

Hypokalemia	10 (48%)
Hemodilution	10 (48%)
Thrombocytopenia	4 (19%)
Shunt occlusion	4 (19%)
Shunt infection	1 (5%)
Coagulopathy	0 (0%)

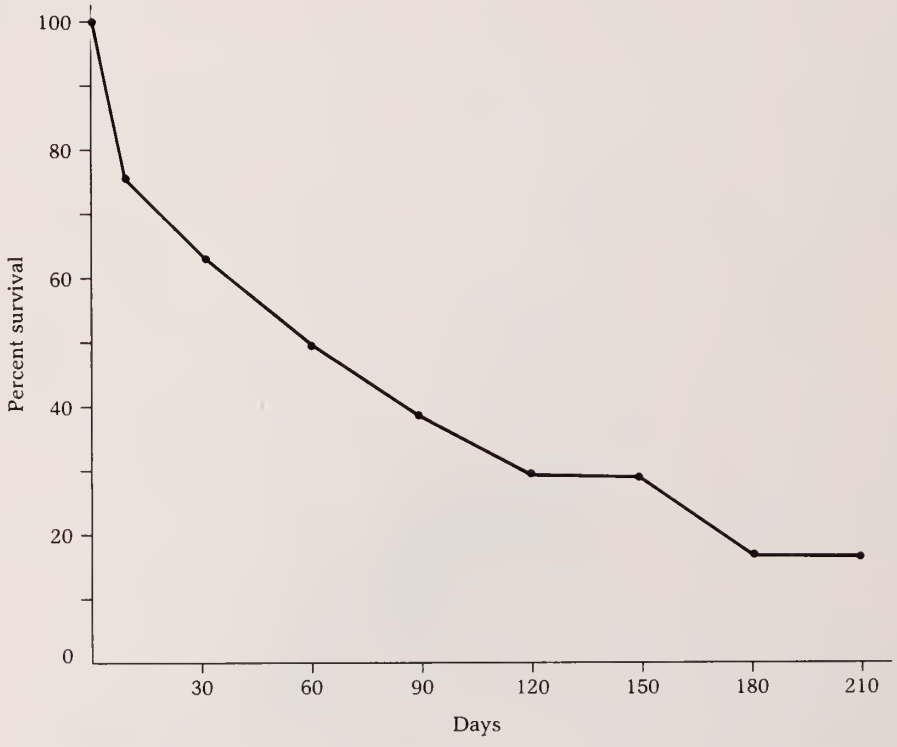
Long-term survival of 21 patients with malignant ascites after peritoneovenous shunt placement

Discussion

Peritoneovenous shunts provide safe and effective palliation of malignant ascites when medical management is unsuccessful. Conservative measures have included diuretics, fluid restriction, paracentesis, and intra-abdominal radiocolloids or chemotherapy.[7] Peritoneovenous shunts have been shown to provide successful relief from the incapacitating symptoms of malignant ascites.[3-5]

Prior studies have discussed numerous complications including those identified in this study.[4,5,8] Disseminated intravascular coagulation is a major concern after placement of a peritoneovenous shunt for ascites secondary to alcoholic cirrhosis, but has not been significant in association with malignant ascites.[7] Several studies have reported this complication, but its incidence has decreased, and most patients had had abnormal liver and coagulation profiles prior to surgery.[9] One study showed minimal changes in platelet count or elevation in fibrin degradation products in patients who had functioning shunts.[5] These values did return to normal, and no evidence of disseminated intravascular coagulopathy was identified. Similar results were obtained in our study. Four patients (19%) experienced thrombocytopenia and three (14%) had minor elevations of the prothrombin time without any clinical evidence of bleeding.

Obstruction of the peritoneovenous shunt has occurred, especially in patients with high protein content in the ascitic fluid.[10] Evaluation for occlusion has been assessed with



Long-term survival of 21 patients with malignant ascites after peritoneovenous shunt placement

radionuclide scan, direct puncturing and withdrawal of ascitic fluid, or Doppler studies.[6] The occluded portion can be surgically revised using local anesthetic without replacement of the entire shunt or complications and with minimal difficulty. Five patients (24%) in our study had evaluation by shuntogram for nonfunctioning shunts, and two patients underwent shunt revision. One of these patients had the abdominal and venous portions replaced on separate occasions. Surgical revision was not performed in a third patient because of multiple loculations. Functioning peritoneovenous shunts were evident in the other two patients studied.

Serious complications are relatively infrequent and rarely contraindicate placement of a peritoneovenous shunt for malignant ascites. Obviously those patients who have more advanced metastatic disease are at higher risk for complications and have shorter survival times after shunt placement. In our series, complications were minor and were easily managed or corrected. There were no shunt-related deaths in this study.

Mortality due to progression or complications of the primary malignant process is inevitable. In this study, 30-day mortality was 38%, and mean survival was 81.6 days. Several studies state that patients whose death is imminent should not undergo shunt placement, but it is difficult, if not impossible, to determine longevity prior to shunt placement. Obtaining palliative relief from the clinical symptoms of malignant ascites becomes the primary goal for these patients, and it can be achieved effectively with few major complications.

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Loss Prevention Corner

Common mistakes in medical liability suits

Michael C. Reineck, MD
West Bend

Physicians need to be aware of the common and avoidable mistakes that might be made during the initial stages of shock and disbelief when facing a professional liability suit. The following is a list of the ten most common errors which may hurt your case.

Altering records

There is no defense for this blunder. Resist the temptation to improve or embellish your records. Under scrutiny, all alterations of records are easily detectable. Any alteration will be interpreted as deceit to cover an error. Your testimony will lose its credibility, and the jury will perceive you as dishonest.

Contacting plaintiff's attorney or plaintiff

Your best bedside manner or logic will not make the suit go away. Your patient has already lost confidence in you and feels betrayed. The plaintiff's attorney reviewed the case and expects to be reimbursed for his efforts. Your call will probably reaffirm their beliefs and may provide them with information to be used against you.

Unprotected correspondence

You will be asked to produce all correspondence, notes, and summaries relative to the case. Any statement other than to your attorney is discoverable. To protect yourself, communicate only through your attorney.

Failure to disclose fully to your attorney

Absolute honesty with your attorney is necessary for a successful outcome. Incorrect or inadequate information will mislead your attorney in planning your defense. A thorough review of both the strengths and the weaknesses of your case will prepare you and your attorney to respond.

Poor courtroom appearance or attitude

You are judged not only by what you say, but how you say it, and how you look when you say it. It is in your best interest to appear confident. Arrogance and unusual clothing alienate the jury. Meekness will be interpreted as guilt. When talking, speak slowly and concisely. Talk to the jury, not at them. Explain your treatment at a level that is easily understood by a layman, but do not demean the jury by talking down to them.

Unprepared for deposition or trial

A trial or deposition, like an exam, requires adequate preparation. Review all notes and records pertaining to the case, especially nursing notes. Be familiar with current literature, pro and con, particularly any you may have published. Likewise, review any previous deposition(s) you may have given in this and other cases. Strive for consistency in your presentation.

Failure to familiarize your attorney of the medical facts

You are responsible to provide your attorney with medical information to prepare your case. An honest discussion of weak and strong medical points will help your attorney anticipate and counter potential problems. Your professional contacts may assist your attorney in providing medical experts to defend your case. You are a team—but remember, on this team you are the first mate, not the captain.

Provide only copies of notes, reports and x-rays when requested

Documentation is paramount to a successful defense. The original records are safest in your possession. Personally review what copies are forwarded and make sure your hospital has a similar policy of sending out only copies, especially of x-rays. Do not alter or edit any records before copying them.

Discussion of your case with colleagues

You will be asked with whom you discussed the case. The only

Dr Reineck is a member of the SMS Medical Liability Committee and Risk Management Subcommittee. The *Wisconsin Medical Journal* thanks the American Academy of Orthopedic Surgery for permission to publish this article. Questions regarding the SMS Physician Support Group should be directed to Mark Adams, SMS Division of Medical Policy and Practice at 1-800-362-9080 or 608-257-6781.

conversations which are protected are those with your attorney or those held in his presence. Be especially careful when asked to comment on a colleague's care. This may be a subtle way of obtaining information against you.

Not concisely answering the questions asked

Answer only what is asked no matter how friendly or solicitous the plaintiffs' attorneys seem. Remember they are advocates for the plaintiffs, and their job is to win. Questions are asked not only to obtain information, but to stimulate a reaction. Therefore, never try to show how smart you are or how uninformed the plaintiffs' attorneys may seem, and never answer a question unless you understand it. The one person present to help you is your attorney.■

Medicare: questions and answers

Q. I'm a nonparticipating physician and assisting at surgery. Will I have an MAAC for this service, or can I bill a percentage of the surgeon's fee?

A. You must charge according to your MAAC when billing for the assistant's fee. The MAAC may be found on your provider pricing profile, and is identified by the type of Service 8. If it is not on your profile, you may request your MAAC by writing to Medicare.

Q. I'm a participating physician. Is there a special phone line I may use to call Medicare?

A. Yes. To receive this phone number, call Medicare Inquiry Services at 608-221-3330, identify yourself, and you will be given the phone number.

Q. Is it true that beginning July 1, 1988, Medicare may not pay claims in less than ten days after receipt?

A. Yes. The 1987 Omnibus Budget Reconciliation Act requires Medicare to hold payment on claims for ten days beginning July 1, 1988. Beginning October 1, 1988, Medicare will not pay claims in less than 14 days. This is true for both paper and electronic claims.

Q. I'm providing the technical component of a diagnostic radiology test and sending it to a radiologist's office to be interpreted. With the new purchased diagnostic requirements, how should I submit my claim to Medicare?

A. You should submit your claim for the technical component of the purchased diagnostic test and add the statement "no purchased diagnostic tests" in box 24C of the HCFA 1500 claim form.

Q. I am supplying only the professional component of a purchased diagnostic test. Do I need to state "no purchased diagnostic test" on my claim?

A. No, this statement is not required if you are performing only the professional component. Medicare will identify these claims by the type of service.

Q. If I bill for a surgery using a 22 modifier, is my charge used to determine my future reimbursement?

A. No, charges submitted with a 22 modifier are not used to determine future reimbursements.

Q. I'm a participating provider. Should I use priority labels on every claim I submit to Medicare?

A. Yes, a priority label should be used on each claim you submit to Medicare. You should also use a label on the outside of the mailing envelope. These labels can be ordered by writing to the Claims Control Department at Medicare or by calling the participating provider phone line. Using these labels will ensure special handling and rapid processing of your claims.

Q. I received my clinical lab fee schedule which specifies two columns of reimbursement. Which column is my approved amount?

A. The clinical lab fee schedule specifies columns of 60% and 62% reimbursements. The 60% figure is allowed if the service is performed in the physician's office or an independent laboratory. The 62% figure is allowed if the service is performed in an outpatient department of a hospital.

Q. My payments from Medicare are still being reduced by 2.324%. I thought the Gramm-Rudman-Hollings Act ended March 31, 1988?

A. The 2.324% reduction did end in March, but the reduction is applied by date of service. If Medicare processes a claim for a date of service before May 1, 1988, it will continue to reduce your payment.

If you have questions about Medicare that you would like to see answered in this column, send them to: Medicare Q&A, c/o Karen Lord, State Medical Society of Wisconsin, PO Box 1109, Madison, WI 53701.■

The cost of health care

Health expenditures in 1987 totaled $499 billion, accounting for 11.2% of the nation's Gross National Product, according to the US Department of Commerce. Hospital expenditures represented 39% of total health care costs, with physician services adding an additional 20%. Government programs paid for 41% of the bill.■

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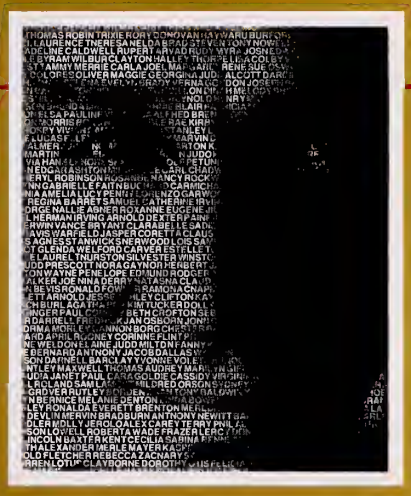

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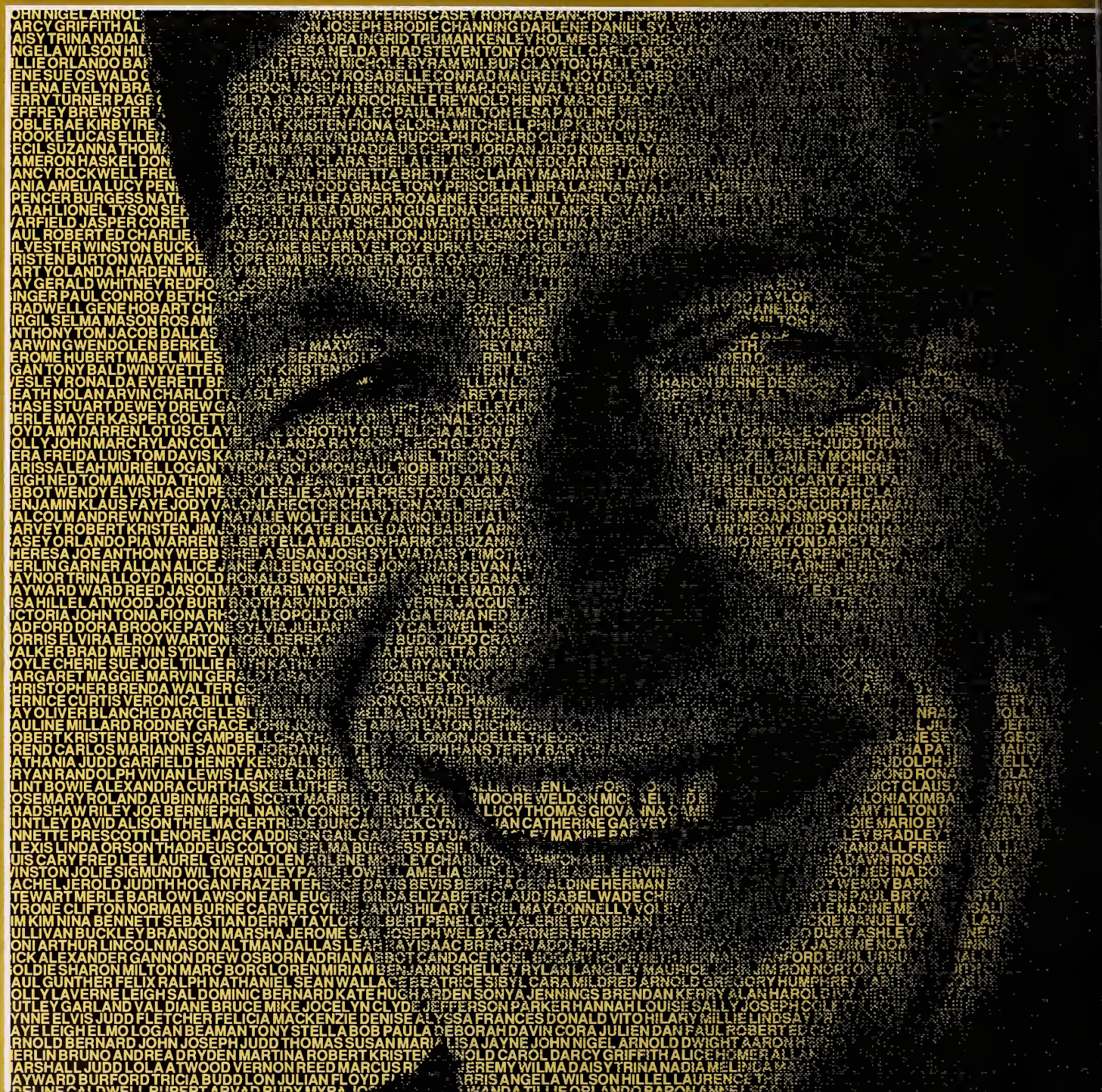

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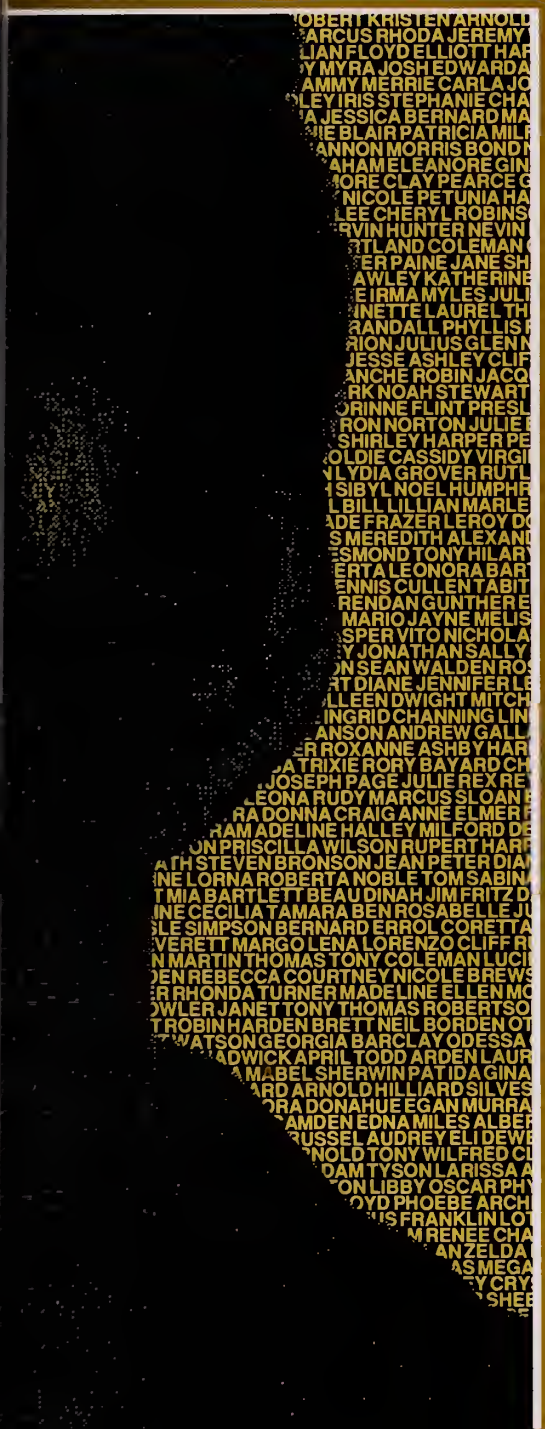

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INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure, and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

> IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3, and decreasing T_3.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL (propranolol HCl) is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, *phenobarbitone*, and *rifampin* accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and *lidocaine* have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

Reference:

1. Data on file, Ayerst Laboratories.

D7295/188

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Legislative wrap-up: 1987

At the end of March, the 1987 session of the Wisconsin legislature adjourned its regular session. The following report is presented to identify issues of interest to SMS and the ending status of those bills. To obtain further information on these issues, please contact Terry Hottenroth, director, SMS Division of Public Affairs, or Don Lord, manager, SMS Governmental Relations at 608-257-6781 or 1-800-362-9080.

Bill	Position	Status
Seat belts (SB 7, AB 7, AB 48, AB 164): Requires motor vehicle operators and passengers to be properly restrained by seat belts. Law sunsets June 30, 1989.	Support	SB 7 became law, 1987 Wis Act 132
Smoking by minors (SB 10, SB 139, SB 262, AB 35, AB 109, AB 111, AB 390): Effective July 1, 1989, prohibits the sale or distribution of tobacco products to minors.	Support	AB 390 became law, 1987 Wis Act 336
Disabled parking privileges (SB 24): Authorizes chiropractors to certify a disabling condition in order for persons to obtain special plates or identification cards for parking privileges.	Oppose	Law, 1987 Wis Act 19
Physical therapists practice (SB 58, AB 178): Authorizes physical therapists to evaluate and treat patients without the referral from a physician, dentist, or podiatrist.	Oppose	AB 178 passed Assembly. Both bills died in Senate committee
Chiropractic mandate (SB 100—Budget Bill): Mandates coverage of chiropractic services under health insurance, HMOs, and PPOs.	Oppose	Law, 1987 Wis Act 27
Optometry therapeutic drugs (SB 125, AB 161): Authorizes optometrists to diagnose eye disease and treat through use of therapeutic drugs.	Oppose	Died in Senate and Assembly committees
Dental hygienist practice (SB 126, AB 292): Alters the supervisory requirement of dentists for dental hygienists' services provided at the dentists' direction. (Originally opposed by SMS before a compromise was struck. As introduced, the bill authorized independent practice for dental hygienists.)	Support compromise	AB 292 became law, 1987 Wis Act 316
Pharmacist practice (AB 142): Implements in the statutes a Pharmacy Examining Board administrative rule which authorizes pharmacists to initiate or administer drug treatment, or modify a prescription order, pursuant to previously written guidelines between the pharmacist and a prescribing practitioner (see SB 296).	Oppose	Died in Senate committee
IPA reporting (SB 149): Authorizes the insurance commissioner to promulgate administrative rules requiring Individual Practice Associations (IPAs) to submit information for purposes of determining the financial stability of the association. Health care providers making up the IPA are exempt from submitting individual financial information.	Monitor	Law, 1987 Wis Act 247
ATV safety (SB 153, AB 57): Instates safety requirements for operation of all-terrain vehicles, including protective headgear and restricting operation by children.	Support	Died in Senate and Assembly committees

Bill	Position	Status
65 Speed limit (SB 155, SB 166, SB 476, AB 240, AB 823): Increases the speed limit from 55 to 65 miles per hour on rural interstate highways (SB 166) and other rural divided highways with four or more lanes (SB 476).	Oppose	SB 166 and 476 became law, Wis Acts 17 and 136
Corporal punishment (SB 163, AB 270, AB 264): With certain exceptions, prohibits school officials from intentionally inflicting physical pain which is used as a means of pupil discipline.	Support	SB 163 became law, 1987 Wis Act 303
MD reports to DOT (SB 213): Authorizes physicians to report name of patient and medical information to the Department of Transportation if, in the physician's judgment, the patient's physical or mental condition is likely to affect driving ability. Good faith reporting, or not reporting, is immune from liability.	Support	Law, 1987 Wis Act 40
Diabetes coverage (SB 233): Extends to Dec 31, 1992, the required insurance coverage of installation and use of insulin infusion pumps, and diabetic self management programs. Current law sunsets Dec 31, 1988.	Oppose	Law, 1987 Wis Act 327
Admissability of evidence (SB 246): Clarifies that formal panel findings must be admitted as evidence if either side introduces them. This law applies to those cases which still exist under the former Patient Compensation Panel system.	Support	Law, 1987 Wis Act 118
Occupational therapists (SB 261, AB 425): Certifies and regulates occupational therapists through the Medical Examining Board.	Support	Passed in Budget Bill, AB 850, 1987 Wis Act 399
Service corporations (SB 266): Authorizes persons other than those who are licensed, certified or registered by the state to engage in a particular profession or trade to be a director or officer of a service corporation.	Oppose	Died in Senate committee
Respiratory therapists (SB 283): Certifies and regulates respiratory therapists through the Medical Examining Board.	Support	Passed Senate. Died in Assembly
Drug substitution (SB 296, AB 472): Repeals a Pharmacy Examining Board administrative rule which allows pharmacists to initiate or administer drug treatment, or modify a prescription order, pursuant to previously written guidelines between the pharmacist and a prescribing practitioner. Hospital pharmacy and therapeutics committees may authorize such practice for hospital inpatients.	Support	SB 296 became law, 1987 Wis Act 65
Baby Doe (SB 300, AB 465): Establishes a mechanism for reporting, investigating, and requiring treatment in cases involving potential or suspected medical neglect of disabled or handicapped infants or children.	Oppose	Died in Senate and Assembly committees
Medical IRAs (SB 313, AB 456): Allows persons to establish trust accounts to pay for future medical expenses, including long-term care, and make tax-deductible contributions of up to $2,000 annually.	Support	Died in Senate and Assembly committees
Diabetes supplies (SB 324): Provides a sales tax exemption on equipment and supplies used to determine blood sugar levels by diabetics.	Support	Died in Senate committee
Tort reform (SB 330): Makes the following modifications in civil liability suits: a) places a $250,000 cap on non-economic damages, b) limits liability of joint tort-feasors to his or her proportionate share, c) restricts recovery from a collateral source, d) limits or establishes a review procedure for attorney contingency fees, and e) restricts awards for punitive damages.	Support	Died in Senate committee

Bill	Position	Status
Mental commitment (SB 351): Makes several changes to the laws governing civil commitment procedures and standards for mentally ill persons.	Support	Law, 1987 Wis Act 366
Juvenile commitment (SB 352): Establishes a court review procedure where a minor 14 or older or the minor's parents refuses mental health treatment.	Support	Law, 1987 Wis Act 367
Community support programs (SB 353): Provides increased state assistance to local governments for the development of mental health community support programs.	Support	Law, 1987 Wis Act 368
Health data (SB 357, AB 623): Establishes an office of health care information within the Department of Health and Social Services for purposes of collecting, analyzing and disseminating health care data.	Support	Passed in Budget Bill, AB 850, 1987 Wis Act 399
Smoking regulation (SB 358, AB 615): Expands the Clean Indoor Air law to private offices, and makes other minor modifications to the law.	Support	SB 358 passed Senate. Both bills died in Assembly
Inmate HIV testing (SB 417, AB 717): Authorizes HIV testing of inmates if convicted of certain offenses or if they have engaged in assaultive behavior prior to or during confinement.	Support with modifications	Died in Senate and Assembly committees
Insurance mandate (SB 443, AB 493): Requires the insurance commissioner to submit social and financial impact statements to the legislature on bills mandating coverages under health insurance.	Support	SB 443 Passed, 1987 Wis Act 177
Hospital board membership (SB 507, AB 865): Requires at least two registered nurses to serve as members of a hospital's governing body.	Oppose	Died in Assembly and Senate committees

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Bill	Position	Status
Nursing student loans (SB 508, AB 880): Establishes nursing student loans for second year VTAE program, and junior and senior year bachelors degree program. Principle will be forgiven if nurse is employed five years in a hospital, or four years in nursing home, subsequent to graduation.	Support	Passed in Budget Bill, AB 850, 1987 Wis Act 399
Nursing education study (SB 509, AB 867): Require the VTAE Board and UW Board of Regents to appoint a committee to study orderly transfer of academic credits from VTAE nursing programs to a bachelor's degree program.	Support	AB 867 became law, 1987 Wis Act 341
Nursing incentive grants (SB 510, AB 863): Establishes a nursing incentive grant program and a 14-member advisory council within the Department of Health and Social Services. Grants are available to nursing schools, hospitals, nursing homes, and other facilities or agencies in which nurses are employed.	Support	AB 863 passed, vetoed by governor
Living wills (SB 567, AB 297): Modifies current law on living wills to authorize declarants to consent to the withdrawal or withholding of nutritional support or fluid maintenance that is not ingested orally or that is not necessary to maintain comfort.	Support	Died in Senate and Assembly committees
Sale of organs (AB 23): Prohibits economic gain in the acquisition, receipt, or transfer of human organs or tissues used for transplantation.	Support	Law, 1987 Wis Act 97
Gunshot and crime injuries (AB 108): Requires physicians and other providers to immediately report to local law enforcement the incidence of gunshot wounds or other injuries believed to be inflicted as the result of a crime.	Support	Law, 1987 Wis Act 233
Water heater safety (AB 163): Requires water heater manufacturers to preset thermostats at no higher than 125° F., or the lowest possible setting.	Support	Law, 1987 Wis Act 102

Bill	Position	Status
Motorcycle helmets (AB 165): Requires operators and passengers of motorcycles to wear protective headgear.	Support	Died in Assembly committee
Non-Smoker premium discount (AB 154): Provides a 10% premium discount for non-smokers enrolled in the Group Life Insurance Program.	Support	Died in Assembly committee
HIRSP Modifications (AB 203): Makes various revisions to laws governing Wisconsin's Health Insurance Risk Sharing Program (HIRSP) to make the coverage more affordable and available.	Support	Died in Assembly committee
Fetal monitoring tracings (AB 218): Prohibits the destruction of medical records, including fetal monitoring tracings, unless the patient is notified in advance of his or her right to obtain the records. (Both budget bills adopted compromise language concerning fetal monitor tracings. No notification is required if the tracing is more than five years old or if the destruction occurs after the tracing is preserved on microfilm.)	Oppose (support budget amendments)	Compromise proposal passed in Budget Bills, 1987 Wis Acts 27 and 399
D and O liability (AB 301): Limits liability in suits against corporate directors and officers and volunteers of nonprofit organizations.	Support	Law, 1987 Wis Act 13
Long-term care insurance (AB 382): Directs the Department of Health and Social Services to design long-term care insurance programs and submit a proposal to the legislature.	Support	Died in Assembly committee
Mental health (AB 394): Removes the minimum mandates on insurance coverage of nervous and mental disorders and alcoholism and other drug abuse. Requires instead that insurance cover these services in accordance with the terms of coverage of other general medical or hospital treatments.	Support in concept	Died in Assembly committee
Drinking age (AB 432, AB 919, AB 928): Reduces the age for the procurement and consumption of alcohol beverages from age 21 to 19 (AB 928 age 18).	Oppose	Died in Assembly committee

Bill	Position	Status
Birth outcome monitoring (AB 531): Requires physicians who diagnose or reasonably suspect that an infant or child suffers from an adverse neonatal outcome, birth defect or other severe disability to report those cases to DHSS. Rules are to be developed to specify reportable conditions. Effective Jan 1, 1989.	Support	Law, 1987 Wis Act 371
Emergency detention (AB 572): Grants psychiatrists and psychologists the same emergency detention powers as law enforcement.	Oppose	Died in Assembly committee
Marriage HIV test (AB 633): Requires applicants for a marriage license to provide proof to the county clerk that each person has been tested for HIV infection and informed of the result.	Oppose	Died in Assembly committee
HIV Testing and disclosure (AB 678): Expands listing of circumstances under which disclosure of HIV test results can be made and authorizes HIV testing under certain circumstances.	Support	Law, 1987 Wis Act 70
Infertility coverage (AB 798): Requires insurance coverage of infertility procedures, including in vitro fertilization.	Oppose	Died in Assembly committee
Patients Compensation Fund (AB 850—Budget Bill): Revises one of the formulas used to determine premium increases to the Patients Compensation Fund. Current law authorizes increases at a rate of 200% of estimated claims paid in the previous *fiscal* year. This revision amends the formula to 200% of actual disbursements made in the previous *calendar* year. The net effect is estimated to limit fund premium increases by $7 million.	Support	Passed, 1987 Wis Act 399

continued on page 46

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INDICATIONS AND USAGE: BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis, in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2. For the prevention of potassium depletion when the dietary intake is inadequate in the following conditions: Patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, and with certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS: Potassium supplements are contraindicated in patients with hyperkalemia since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: Chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene).

Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to enlarged left atrium.

All solid dosage forms of potassium chloride supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation.

WARNINGS: Hyperkalemia—In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic. The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction with Potassium Sparing Diuretics—Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene) since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions—Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage or perforation.

K-DUR tablets contain micro-crystalloids which disperse upon disintegration of the tablet. These micro-crystalloids are formulated to provide a controlled release of potassium chloride. The dispersibility of the micro-crystalloids and the controlled release of ions from them are intended to minimize the possibility of a high local concentration near the gastrointestinal mucosa and the ability of the KCl to cause stenosis or ulceration. Other means of accomplishing this (e.g., incorporation of potassium chloride into a wax matrix) have reduced the frequency of such lesions to less than one per 100,000 patient years (compared to 40–50 per 100,000 patient years with enteric-coated potassium chloride) but have not eliminated them. The frequency of GI lesions with K-DUR tablets is, at present, unknown. K-DUR tablets should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis—Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, potassium acetate, or potassium gluconate.

PRECAUTIONS: The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium. The treatment of potassium depletion, particularly in the presence of cardiac disease, renal disease, or acidosis requires careful attention to acid-base balance and appropriate monitoring of serum electrolytes, the electrocardiogram, and the clinical status of the patient.

Laboratory Tests: Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions: Potassium-sparing diuretics; see **WARNINGS.**

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C: Animal reproduction studies have not been conducted with K-DUR. It is also not known whether K-DUR can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. K-DUR should be given to a pregnant woman only if clearly needed.

Nursing Mothers: The normal potassium ion content of human milk is about 13 mEq per liter. Since oral potassium becomes part of the body potassium pool, so long as body potassium is not excessive, the contribution of potassium chloride supplementation should have little or no effect on the level in human milk.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: One of the most severe adverse effects is hyperkalemia (see **CONTRAINDICATIONS, WARNINGS,** and **OVERDOSAGE**). There have also been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see **CONTRAINDICATIONS** and **WARNINGS**); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE: The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see **CONTRAINDICATIONS** and **WARNINGS**). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration and characteristic electrocardiographic changes (peaking of T-waves, loss of P-waves, depression of S-T segment, and prolongation of the QT-interval). Late manifestations include muscle-paralysis and cardiovascular collapse from cardiac arrest.

Treatment measures for hyperkalemia include the following:

1. Elimination of foods and medications containing potassium and of potassium-sparing diuretics.

2. Intravenous administration of 300 to 500 ml/hr of 10% dextrose solution containing 10–20 units of insulin per 1,000 ml.

3. Correction of acidosis, if present, with intravenous sodium bicarbonate.

4. Use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia, it should be recalled that in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

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continued from page 45

Bill	Position	Status
Medical record copying costs (AB 904): Removes the ability of health care providers to assess reasonable costs to patients for copying medical records requested by patient.	Oppose	Died in Assembly committee
HIV Prevention (AB 981): Requires schools to provide instructional programs in grades six through twelve on preventing the transmission of HIV infection.	Support	Died in Assembly committee
Seat belt repeal (AB 986): Repeals the law requiring motor vehicle operators and passengers to wear seat belts.	Oppose	Died in Assembly committee
Hospital DRGs (SJR 29, AJR 52): Urges enactment of federal legislation to change the Medicare DRG system so that rural hospitals are treated equitably with urban hospitals.	Support	SJR 29 Adopted■

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SMS seeks new approach to health insurance

Saying the time had come for government and business to face the issue of uninsured health care, Thomas L. Adams, secretary-general manager of the SMS, proposed an innovative program to provide health insurance to all Wisconsin citizens. Adams' remarks, which included a proposal to convene an SMS task force on the problems of the uninsured, were made before the House of Delegates at the annual meeting. The delegates approved his proposals April 29.

According to Adams, recent surveys show that about 554,000 people in Wisconsin, or 12% of the population, are uninsured, and while most of them are medically or financially unable to obtain insurance, some chose to go without it. He added that some companies hire part-time help to avoid providing even minimal coverage. These companies "extract a financial toll from the rest of society by their irresponsible behavior," he said.

Adams said all Wisconsin employers should provide basic health coverage, including catastrophic, to all workers, who should be required to participate. Under his plan, employers would pay at least 80% of the premium for basic coverage and 100% for low-wage workers. He said such a plan should be administered by private carriers and that employees should be able to choose between competing plans, paying the difference for more expensive ones if they so choose. "State government can help facilitate this effort by providing an income or excise tax credit in the program's early going," he said.■

SMS hosts clinic managers

Clinic managers from around the state enjoyed a reception hosted by SMS Secretary-General Manager Thomas L. Adams at SMS headquarters May 5. The late afternoon, lakeside social was held in conjunction with the Wisconsin Clinic Managers Association spring meeting held at the Radisson Hotel in Madison, May 5 and 6.

More than 100 managers attended the meeting which focused on the theme of "The Politics of Health Care." J. Michael Rona, executive director of the Virginia Mason Medical Center in Seattle, opened the conference by describing how the Washington Clinic Managers Association and the Washington State Medical Society joined forces to defeat a referendum on mandatory assignment in that state.

Peter Lauer, executive director of the American Medical Political Action Committee (AMPAC) reviewed the major health care issues looming on the political horizon and stressed the need for involvement by physicians and clinic managers.

Other notables in attendance included Scott McCallum, lieutenant governor of Wisconsin, Timothy Cullen, secretary of the state Department of Health and Social Services, Diane Ebersberger, director of professional practice of the Wisconsin Hospital Association, and Ned Boston, director of Medicare Administration at WPS.■

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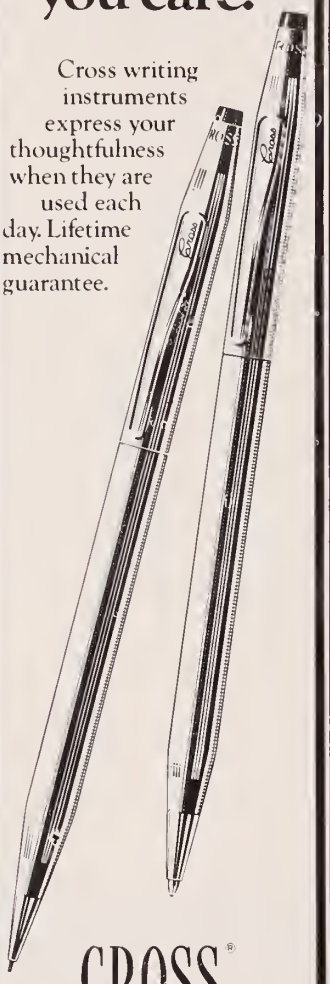

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New officers and directors elected

William L. Treacy, MD, of Milwaukee, is the new SMS president elect. Dr Treacy was elected at the annual meeting April 29 and will assume the presidency at the 1989 Annual Meeting.

Dr Treacy is an internist-rheumatologist and former chairman of the Department of Internal Medicine at St Joseph's Hospital in Milwaukee. He is chairman of the board of WISPAC and a member of the SMS Medical Liability Committee.

The House of Delegates also reelected John J. Foley, MD, of Menomonee Falls, as treasurer. Cyril M. Hetsko, MD, of Madison, was elected vice speaker of the house. J D Kabler, MD, of Madison, automatically assumed the SMS presidency after serving as president elect for the past year.

William L. Treacy, MD

John K. Scott, MD, of Madison, Patricia J. Stuff, MD, of Bonduel, and DeLore Williams, MD, of West Allis, were all reelected to another term on the Wisconsin delegation to the AMA. The new alternate delegate is Jerome W. Fons, Jr, MD, of Cudahy. Dr Hetsko and John P. Mullooly, MD, of Madison, were reelected as alternate delegates.

Elected to the SMS Board of Directors were: Donald A. Wollheim, MD, Marcia J.S. Richards, MD, and Richard H. Strassburger, MD, all of Milwaukee (District 1); James P. Speichinger, MD, of Madison (District 2); Robert J. Jaeger, MD, of Stevens Point (District 4); and Donn D. Fuhrmann, MD, of New London (District 5).

SMS directors reelected to another three-year term were: Kenneth I. Gold, MD, of Beloit; Sandra L. Osborn, MD, of Madison; James J. Tydrich, MD, of Richland Center; Harry J. Zemel, MD, of Fond du Lac; Joseph C. DiRaimondo, MD, of Manitowoc; and Philip J. Happe, MD, of Eau Claire.■

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House of Delegates actions

The House of Delegates considered 38 resolutions and a number of reports from officers, directors, committees and commissions, and a summary of the House's actions follows. The resolutions and reports were widely distributed to delegates, alternates and county medical society officers, and abstracts of the resolutions were published in the March 1988 issue of the *Wisconsin Medical Journal.*

Members of the Society may, upon request, study the official transcript of the meeting at the SMS headquarters in Madison, or receive a copy of the full contents of particular reports or resolutions.

Reference Committee on Socioeconomic Activities

Report B of the Physicians Alliance Commission outlined the efforts of the commission over the past year and Capitol Update, an addendum to the report, provided a wrap up of government action on issues of concern to SMS. ***Action:*** adopted.

Report K of the Committee on Mental Health described the efforts made toward eliminating unwarranted prejudice against mental illness and improving the delivery of care. ***Action:*** adopted.

Report O of the Medical Liability Committee outlined the committee's work on a broad range of issues related to medical liability. ***Action:*** adopted.

Resolution 6 proposed that the required purchase of tail coverage be waived by the Physicians Insurance Company of Wisconsin (PIC-Wisconsin) for physicians who maintain professional liability insurance for five years or longer. ***Action:*** rejected.

Resolution 9 recommended that SMS give high priority to pursuing the enactment limit of $250,000 on noneconomic damages in medical professional liability cases and the repeal of the 1990 sunset on the current limit. The committee recommended the following amendment: "Resolved, that the State Medical Society continue to give high priority during the 1989 Wisconsin Legislature for the enactment of legislation that 1) will limit total recovery for noneconomic damages in medical malpractice lawsuits to $250,000 for both awards and settlements, and 2) will repeal the current sunset of December 31, 1990, on the existing noneconomic damages cap for medical liability awards." ***Action:*** adopted as amended.

Resolution 16 urged the placement of a practicing pathologist or other clinical laboratory representative on the Board of the State Laboratory of Hygiene. ***Action:*** referred to the SMS Board of Directors for assignment to an appropriate committee and further study.

Resolution 19 dealt with risk management courses offered by PIC-Wisconsin and other medical liability insurers. The committee recommended the following amendment: "Resolved, that PIC-Wisconsin and other medical liability insurance companies be encouraged to develop courses of instruction and other resources on medical professional liability risk management." ***Action:*** adopted as amended.

Resolution 20 directed the SMS to form physician support groups throughout the state. The committee recommended the following amendment: "Resolved, that the State Medical Society continue to publicize the availability of the physician support program to the membership on a regular basis, and make the program available to physicians who are threatened with malpractice suits as well as those who have been formally named in a suit." ***Action:*** adopted as amended.

Resolution 21 called for an actuarial study and listing, based on cost savings, of possible reforms in the laws governing medical professional liability. ***Action:*** rejected.

Resolution 22 called for the SMS to file a lawsuit challenging the statutory requirement that all physicians carry unlimited liability coverage via the Patients Compensation Fund. ***Action:*** rejected.

Resolution 23 called for the SMS to support increases in charges to attorneys for records, physicians' depositions, and physicians' testimony. ***Action:*** rejected.

Resolution 24 called for a change in financing of the Patients Compensation Fund and medical professional liability insurance companies whereby judgments and settlements would be paid out of current reserves until those funds are expended, and subsequently yearly premiums would be set at a level equal to yearly payout. ***Action:*** rejected.

Resolution 25 sought to require medical professional liability defense attorneys to agree to pursue legal action against plaintiff's attorneys in frivolous cases. ***Action:*** rejected.

Resolution 26 called for an investigation and redefinition of pro-

cedures for facility inspections, citations for violations, and other actions by the Bureau of Quality Compliance of the Department of Health and Social Services. ***Action:*** referred to the Board of Directors for further study.

Resolution 29 called on the SMS to develop a uniform definition for experimental therapies and procedures, and to establish a central information clearinghouse. ***Action:*** referred to the SMS Board of Directors, for possible reformulation and submission to the AMA House of Delegates.

Resolution 32 sought to facilitate the issuance of temporary parking permits for the disabled. The committee recommended the following amendment: "Resolved, that the State Medical Society facilitate an alteration in state statute or administrative code to assure the temporary issuance of disabled permits in a patient's home locality on a timely basis." ***Action:*** adopted as amended.

Resolution 34 urged support for legislatively mandated insurance coverage for investigation and treatment of infertility problems. ***Action:*** rejected.

Resolution 37 urges the SMS to continue seeking state funding for vaccine purchases in the Wisconsin Immunization Program, thereby enabling local public health departments to provide immunizations to those in need. The committee recommended deleting a second "resolved" clause which would have sent copies of the resolution to the governor and all legislators. ***Action:*** adopted as amended.

Resolution 38 recommended that the SMS call for physicians who advertise a specialty for which they are not board-certified to include a disclaimer in their ads. ***Action:*** rejected.

Reference Committee on Organization and Finance

Resolution 2 called for the SMS to study physician needs for contract review and negotiation services and to provide such services if warranted. The committee offered a substitute resolution: "Resolved, the Young Physicians Section meet with SMS staff to study the mechanism for physician contract review and disseminate its findings to young physician members." ***Action:*** adopted as amended.

Resolution 3 was amended by the committee to read: "Resolved, that the SMS develop an informational publication to help physicians select a malpractice carrier, and it be distributed to SMS members, including medical students and residents upon request." ***Action:*** adopted as amended.

Resolution 27 urged SMS to hold a portion of its meetings in the northern half of the state. ***Action:*** rejected.

Resolution 35 proposed a constitutional change in the election of the president elect. ***Action:*** held over until the 1989 Annual Meeting, as required by SMS Bylaws.

Report D Commission on Public Information, with informational reports on Wisconsin Physicians Political Action Committee; Charitable, Educational and Scientific Foundation; AIDS Task Force; and SMS Services, Inc. ***Action:*** filed.

Report Q recommended a strategic plan for the SMS, a dues increase of $15 for 1989, an expanded Impaired Physician Program funded by an additional $15 dues increase, and the following Bylaws change: "Chapter I, Section 10 C. Physicians in residency or fellowship training: dues and assessments to be determined by the Board of Directors." ***Action:*** adopted.

Treasurer's report: The committee noted the presence of tobacco stock on the list of SMS investments and recommended that, in the future, the SMS General Fund investment portfolio not include stock or bonds of companies that generate a significant amount of their revenues from the production of tobacco products. ***Action:*** received.

Reference Committee on Scientific Activities

Resolution 4 recommended establishment of procedures for the release of medical information to assure confidentiality while allowing timely exchanges of information for insurance and review purposes. The committee recommended deletion of the words "work with the insurance commissioner to." ***Action:*** adopted as amended.

Resolution 5 requested support for legislation to prohibit high speed pursuits of traffic law violators by law enforcement officials. ***Action:*** referred to the Committee on Safe Transportation for further study.

Resolution 7 recommended that the Society endorse the Advance Trauma Life Support course sponsored by the Committee on Trauma of the American College of Surgeons and to encourage physicians involved in emergency care to take the course. ***Action:*** rejected.

Resolution 11 recommended support for legislation requiring restaurants to specify on the menu when alcohol is used in the preparation of food. ***Action:*** rejected.

Resolution 15 advocated a routine, voluntary HIV-antibody test for prospective surgical patients, and requested that test results be considered when determining the appropriateness of surgery, and further, that the patient's antibody status and the safety of health care workers be considered in the treatment plan. ***Action:*** rejected.

Resolution 17 requested endorsement of the concept of teacher/National Athletic Trainers Association-certified trainers for Wisconsin high schools. The committee recommended deletion on line 34 of "5 to" and the addition of the following clause: "Resolved, that athletic trainers would serve on site in association with volunteer team physicians." ***Action:*** adopted as amended.

Resolution 28 supported the voluntary physician-patient relationship, which includes the right of either the patient or the physician to discontinue the relationship. ***Action:*** rejected.

Resolution 31 recommended the development of "criteria for public safety" at major public events. ***Action:*** adopted and referred to the Board of Directors for implementation.

Resolution 36 called for a task force to investigate the need for categorization of critical care capabili-

ties of Wisconsin hospitals and asked that the state delay adoption of categorization or designation of systems until the task force work is completed. The committee recommended the deletion of the clause: "Resolved, that the Legislature be asked for a clarification of its intent in Statute 146.301 (6)." ***Action:*** adopted as amended.

Report A noted that the SMS Commission on Continuing Medical Education has been awarded four years of full accreditation. The committee also noted the commission's concern over the lack of participation in the Annual Meeting by a number of medical specialties. ***Action:*** accepted.

Report C reviewed the activities of the Commission on Mediation and Peer Review and its subcommittees. ***Action:*** adopted.

Report E, of the Editorial Board, outlined the scientific and special papers submitted and reported the establishment of a writing contest for medical students and residents. Also reported were the retirements of Dr Victor S. Falk, after 25 years as medical editor, and Managing Editor Mary Angell, after 30 years with the *Wisconsin Medical Journal.* ***Action:*** accepted.

Report F reviewed a number of issues addressed by the Committee on Aging, Extended Care Facilities and Home Health Care. ***Action:*** accepted.

Report G discussed the activities of the Committee on Alcoholism and Other Drug Abuse, and its cooperation with state and other agencies concerned with substance abuse. ***Action:*** accepted.

Report I summarized the activities of the Committee on Maternal and Child Health, noting legislation reviewed and projected programs. ***Action:*** accepted.

Report J noted that, on directive from the SMS Board of Directors, bioethical issues have been the priority for the Committee on Medicine, Religion and Ethics. ***Action:*** accepted.

Report L issued guidelines for drawing blood for chemical testing for law enforcement, revised by the Committee on Safe Transportation. The Reference Committee on Scientific Affairs recommended approval of the guidelines and adoption of a policy statement on medical examination for safety belt usage, which was included in the report, and directed the Society to inform physicians of, and oppose, the sunset date on the seat belt law. ***Action:*** accepted as amended.

Report M requested approval of four recommendations: 1. a slight modification of the committee's original charge, 2. support for the Smoke Free Class of 2000 program, 3. support for the recommendation by the Department of Public Instruction and the Department of Health and Social Services that instruction about AIDS be integrated into health education curricula, and 4. discontinuing scoliosis screening programs in schools. ***Action:*** accepted.

Reference Committee on National Issues

Resolution 1 called for the SMS to continue working with the AMA and HCFA to correct discriminatory practices in the implementation of Maximum Allowable Actual Charges. ***Action:*** adopted.

Resolutions 8 and 33 urged the SMS to work toward correcting the inequities of physician reimbursements under the present Medicare system. ***Action:*** adopted.

Resolution 10 called for the SMS to assume the scientific position that a fertilized ovum is a human embryo and potentially a human being, and for the SMS to support the US Department of Health and Human Services' position that family planning programs receiving federal funds may not provide abortion counseling or referrals and may not engage in lobbying or legal action to increase the availability of abortions. ***Action:*** referred to the Committee on Medicine, Religion and Ethics for further study, with a directive to report to the SMS House of Delegates at the 1989 Annual Meeting.

Resolution 12 asked the SMS to support the development and

continued on page 52

Viste bids farewell

In his remarks as outgoing president of the SMS, Kenneth M. Viste, Jr, MD, reviewed the Society's accomplishments during the past year. He said his presidency had been directed toward ensuring access and availability to affordable health care for all Wisconsin citizens. He noted the successful implementation of PartnerCare across the state, and called for the creation of a special committee to ensure its continued success. He also reviewed the accomplishments and the recommendations of the Task Force on Rural Health, which he chaired. Other significant activities of the SMS during 1987–1988, according to Dr Viste, were the development of the Strategic Plan and the work of the AIDS Task Force and the SMS Blue Ribbon Task Force on Alternatives to the Tort System.

Looking toward the future, Dr Viste said the Society should work hard to ensure its continued success with the public and with elected officials. He recommended keeping a strong central staff to analyze issues and help formulate policy. He also said the Society "needs to reach out to our widely scattered members so that they may become better informed and may participate more fully in the creation and execution of our policies."

He also recommended that SMS leaders and staff become more visible and more active across the state on major health issues such as seat belts, drunk driving laws and AIDS. "It is in many of these areas that we as physicians are the most knowledgeable resources for society, and we must stand up for what we know is right and we must work for policies that enhance the health of our fellow citizens," Dr Viste said.■

enforcement of hazardous air emissions rules by the Department of Natural Resources. ***Action:*** adopted.

Resolution 13 was amended by the committee as follows: "Resolved that the State Medical Society of Wisconsin work for the introduction of legislation which would require that all enclosed public places be maintained as totally smoke free environments." ***Action:*** adopted as amended.

Resolution 14 called for the SMS to oppose recent changes in Medicare regulations alleged to encourage surgeons to delegate postoperative care to non-physicians. ***Action:*** referred to the Section on Ophthalmology for review and reconsideration.

Resolution 18 called upon the SMS and AMA to urge Congress and the president to enact comprehensive clean ambient air legislation without further delay. The committee amended the resolution to require copies of the resolution to be sent to the medical societies of states bordering Wisconsin and to the Indiana State Medical Association. ***Action:*** adopted as amended.

Resolution 30 called upon the SMS to define the ethical issues of financial incentives for restricting or limiting access to care in managed health plans. ***Action:*** referred to the Board of Directors for further discussion, with a directive to report to the House of Delegates at the 1989 Annual Meeting.

Report BB reviewed the major issues addressed by the Committee on Federal Legislation of the Physicians Alliance Commission. ***Action:*** accepted.

Report H detailed the work of the Environmental and Occupational Health Committee during the past year. ***Action:*** accepted.

Report N summarized the new focus and newly defined charge for the Committee on Health Care Quality, Costs and Utilization. ***Action:*** accepted.

Report R highlighted the deliberations in which the Wisconsin Delegation to the American Medical Association was involved. Notable topics of discussion were AIDS and HIV infection, physicians' rights to dispense drugs, and continued physician difficulties with PROs. ***Action:*** accepted.

Report S noted the Wisconsin Nursing Association-State Medical Society Liaison Committee's policy recommendation of: "The Society supports the concept that nursing move toward two levels of licensure. These levels would be associate degree (technical) and baccalaureate degree (professional) . . ." ***Action:*** adopted.■

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C I B A

References: 1. Data on file, CIBA Pharmaceutical Company. 2. Skoutakis VA, Acchiardo SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride: Bioavailability and safety. *Pharmacotherapy* 1980;4(6):392-397. 3. Skoutakis VA, Carter CA, Acchiardo SR: Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics. *Drug Intell Clin Pharm* 1987;21:436-440.

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1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.
2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure; hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy; and certain diarrheal states.
3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS
Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS
Hyperkalemia (See OVERDOSAGE).
In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics
Hyperkalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions
Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis
Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS
General:
The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients
Physicians should consider reminding the patient of the following:
To take each dose without crushing, chewing, or sucking the tablets.
To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.
To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.
To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests
Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions
Potassium-sparing diuretics: see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility
Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C
Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers
The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use
Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE
The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSAGE AND ADMINISTRATION
The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

HOW SUPPLIED
Tablets—600 mg of potassium chloride (equivalent to 8 mEq) round, buff colored, sugar-coated (imprinted Slow-K)
Bottles of 100 . . . . . NDC 0083-0165-30
Bottles of 1000 . . . . . NDC 0083-0165-40
Consumer Pack—One Unit
12 Bottles—100 tablets each . . . . . NDC 0083-0165-65
Accu-Pak® Unit Dose (Blister pack)
Box of 100 (strips of 10) . . . . . NDC 0083-0165-32
Do not store above 86°F (30°C). Protect from moisture. Protect from light.

Dispense in tight, light-resistant container (USP).

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Summit, New Jersey 07901

C87-31 (Rev 8/87)

C I B A

128-3568-A

*Physician members of the State Medical Society of Wisconsin

Jill M. Stebbins, MD,* recently joined the staff of the Gundersen-Mubarak Clinic in Tomah. Dr Stebbins received her medical degree from the University of Minnesota in Minneapolis and completed an internship and residency at the University of Minnesota–St John's Hospital in St Paul. She is board-certified in family practice and is a diplomate of the American Board of Family Practice. She previously was with the Krohn Clinic in Black River Falls.

Muni H. Patel, MD,* of Milwaukee, has passed the certification examination of the American Medical Society of Alcoholism and Other Drug Dependencies. Dr Patel is the medical director of St Mary's Hill Hospital's Adolescent Substance Abuse Program and is board-certified in psychiatry and child psychiatry.

Gerald C. Kempthorne, MD,* was recently honored for his many years of service to the Spring Green area. Dr Kempthorne received a certificate from Gov Tommy Thompson recognizing his leadership in area health care concerns and a plaque from the local American Legion post. Dr Kempthorne received his MD from the University of Maryland and has been in family practice in Spring Green since 1961. He was president of the State Medical Society of Wisconsin in 1982 and is a past president of the Sauk County Medical Society. He was named Physician of the Year by the Wisconsin Association of Nursing Homes in 1981.

Anthony Pisciotta, MD, of Elm Grove recently received a Distinguished Achievement Award from the Milwaukee Academy of Medicine. The award is presented annually to recognize a Wisconsin physician's outstanding contributions to the advancement of knowledge and the practice of medicine. A professor of hematologic research at the Medical College of Wisconsin, Dr Pisciotta was honored for his research on agranulocytosis.

Kermit L. Newcomer, MD,* of La Crosse, was recently elected to the Board of Regents of the American College of Physician Executives during its 13th National Conference on Health Care Leadership and Management in San Diego. Dr Newcomer is an internist and executive vice president of Gundersen Clinic, Ltd. The American College of Physician Executives is a national professional accrediting association for physicians who have demonstrated achievement in health care leadership and management.

Raymond C. Zastrow, MD,* of Hartland, was recently appointed secretary-treasurer of the College of American Pathologists. Dr Zastrow is associate pathologist and director of hematology and radiochemistry at St Michael's Hospital in Milwaukee. He is active in the State Medical Society of Wisconsin, currently serving as a delegate from the first district, and has served as president of

AMA Physician's Recognition Award Recipients

LISTED BELOW are those physicians in Wisconsin who have earned the AMA Physician's Recognition Award in recent months. The State Medical Society of Wisconsin congratulates these physicians who have distinguished themselves and their profession by their commitment to continuing education:

APRIL 1988

*Ahmad, Muhammad Y., Merrill
*Ayengar, Shanta, Milwaukee
Barry, Daniel J., Madison
*Bauer, William, Milwaukee
Boyle, Austin J., Whitefish Bay
*Brauer, Warren A., Sheboygan
*Brown, Jack D., Sparta
*Burko, Henry, Milwaukee
Cesarec, Robert G., New Berlin
*Chestnut, Janet S., Sparta
*Clothier, W.J. Kilburn, Waukesha
*Cody, Edward F., Beaver Dam
*Crawford, Chester W., Green Bay
*Cummens, Michael L., Genesee Depot
*Diestelmeier, Michael R., Altoona
*Firestone, Thomas J., Cato
Hahn, Michael F., Janesville
*Hankey, Terry L., Waupaca
*Honish, John S., Oconto
*Icken, James N., Columbus
Kaufman, Kiesl K., Milwaukee
*Kirchner, John P., Marshfield
*Knier, Michael S., Oshkosh
*Kuritz, Robert R., Madison
*Lee, Jong Man, Beloit
*Lopez, Basilio F., Milwaukee
*Lyerla, Eric R., Milton
*Miller, Dean D., Hales Corners
*Nemec, George, Woodruff
*Nogler, Robert A., Baldwin
*Paster, Robert M., Oregon
*Patton, Charles H., Racine
Perez, Celestino M., Port Washington
*Rahr, Henry C., Green Bay
*Saunders, Michael J., Tomah
*Schmidt, Robert T., Green Bay
*Skupniewicz, Raymond E., Racine
*Smirl, Warren G., Waukesha
*Van Pernis, Paul, Ashland
*Vinluan, Jeremia B., Milwaukee
*Wagner, Marvin, Milwaukee
*Willerscheidt, Anton B., Washburn

**Members of SMS.* ■

CORRECTION: Jefferson F. Ray, III, MD,* and Cesar N. Reyes, Jr, MD,* from Marshfield, should have been listed as members of the State Medical Society of Wisconsin under the February 1988 listing of the AMA/PRA awards in the April issue of *WMJ*.

the Wisconsin Society of Pathologists. He received his medical degree from Marquette University and is board-certified in anatomic and clinical pathology and in nuclear medicine.

Arnold L. Brown, MD,* of Madison, was recently appointed to the National Board of Medical Examiners as a member of the Steering Committee for the Evaluation of Clinical Skills. Dr Brown is dean of the University of Wisconsin Medical School in Madison.

Mary Ellen Peters, MD,* of Madison, has been named a fellow of the American College of Radiology. The college awards fellowships for significant additions to its literature, outstanding service as a teacher of radiology, contributions to organized medicine and for an outstanding reputation among colleagues at the local community. Dr Peters is a professor of radiology at the University of Wisconsin Medical School.

Everett A. Beguin, MD,* of Onalaska, has been reelected treasurer of the National Perinatal Association for a fourth consecutive two-year term. An obstetrician-gynecologist at Gundersen Clinic, Dr Beguin received his degree from the University of Wisconsin School of Medicine in Milwaukee and is past president of the Wisconsin Association of Perinatal Care.■

NEWS HIGHLIGHTS

*Physician members of the State Medical Society of Wisconsin

The Memorial Hospital of Iowa County, Inc, medical staff has elected Everett R. Lindsey, MD,* president. Also elected to staff offices were Timothy A. Correll, MD,* vice president, and Mark P. Bishop, MD,* secretary. J.M. Lehman, DO, will continue to serve on the executive committee as past president.

Sacred Heart Rehabilitation Hospital in Milwaukee has named William Lange president and chief executive officer. He was previously administrator of Lakeland Hospital in Elkhorn.

Vernon Memorial Hospital of Viroqua announced that Jim Hudson recently retired as chief executive officer. Garith Steiner is serving as interim administrator until a new CEO is named.

FORT CRAWFORD MEDICAL MUSEUM
PRAIRIE DU CHIEN, WISCONSIN

Open daily May 1 through October 31
10 a.m. to 5 p.m.
Adults $2 Children $.50

Three building complex owned by the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin.

Prairie du Chien Memorial Hospital's Harold W. Brown has received the 1988 Louis Gorin Award for Outstanding Achievement in Rural Health Care. This award is presented annually in memory of Louis Gorin, a leader for many years in rural health initiatives at the federal level. Award recipients are selected for their creativity, unselfishness, compassion, and cooperative attitude in seeking ways to improve rural health care. Brown, the chief executive director of the hospital, has been active in developing and implementing programs for the elderly in the Prairie du Chien area.

The St Clare Hospital of Janesville medical staff recently elected Jan E. Erlandson, MD,* president. Other officers elected were Carleton Davis, MD, president elect, and Bharathy V. Nair, MD,* treasurer.

The Mercy Hospital of Janesville medical staff recently elected Ronald P. Karzel, MD,* president of the 1988 Executive Committee. Others elected to the committee were Samuel L. Frazer, MD,* president elect; Richard L. Kochell, MD,* secretary-treasurer; and Dale E. Miller, MD.*■

PHYSICIANS EXCHANGE

Family Practice physicians. BC/BE, two positions available. Two-man group and solo practitioner each seeking additional physician for rapidly expanding practices. Located in southern Florida near Ft Lauderdale. Excellent opportunities with partnership potential after first year. Negotiable salary with incentives, liberal benefit package. Please send CV to Virginia K. Norquist, Nu-Med Hospitals, 16633 Ventura Blvd, 13th Floor, Encino, CA 91436. p6-7/88

Family Practice physician wanted to be associated with branch clinic of a large multispecialty group. Opportunity for family practice in Prairie du Chien, Whitehall, Viroqua or Tomah, Wisconsin; West Union, Iowa. Physician would be associated with a multispecialty group. Relief provided for vacations, meetings, etc. Educational opportunities through an excellent education program. Beautiful countryside, cultural, and recreational facilities. Excellent fringe benefits. Salary commensurate with background and experience. Write or call Tim Skinner, MSEd, Family Practice Representative, Gundersen Clinic, Ltd, 1836 South Ave, La Crosse, WI 54601. Equal Opportunity Employer. 6/88

General Surgeon and **Family Practice** opportunities in a group setting. Located in a family-oriented economically strong small city. Located near lakes and metro area of Green Bay and Appleton, Wis. Send CV to Andrew Lagatta, President, Clintonville Community Hospital, 35 N Anne St, Clintonville, WI 54929. 6-10/88

Family Practice Physician BE/BC, needed to provide primary outpatient care in a free-standing student health service with its own lab facilities for a student population of 11,000 at the University of Wisconsin-Eau Claire. Experience in sports medicine and/or gynecology preferred. Attractive salary and fringe benefit package, including malpractice insurance. Contact: Shelley Bratholdt, RNC, ANP, Director of Health Services, University of Wisconsin-Eau Claire, Eau Claire, WI 54701; ph (715) 836-4311. 6/88

RATES: 50¢ per word, with a minimum charge of $20.00 per ad. BOXED AD RATES: $25.00 per column inch. *All ads must be prepaid.*

DEADLINE: Copy must be received by the 15th of the month preceding month of issue; *eg,* copy for the August issue is due July 15. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 1-800-362-9080.

Family Practice (BC/BE) opportunity to join a five-physician family practice group in south central Wisconsin city of 15,000. Pleasant community atmosphere within 1-1½ hours of Madison and Milwaukee. Excellent recreational area. First year guaranteed salary. Contact: Chad Burchardt, Business Manager, Medical Associates of Beaver Dam, SC, 1200 N Center St, Beaver Dam, WI 53916; ph (414) 887-7101. p6-8/88

Seeking Emergency Department director and full-time physicians for 100-bed hospital 35 miles north of Milwaukee. Excellent compensation, malpractice insurance provided and benefit package available. Contact: Emergency Consultants, Inc, 2240 S Airport Rd, Room 36, Traverse City, MI 49684; ph 1-800-253-1795 or in Michigan 1-800-632-3496. p6/88

BC/BE Family Practice to join six-BEFP and one BC general surgeon in scenic northern Wisconsin. Outstanding recreational area. New clinic facility attached to hospital. First year salary with production incentive. Please send CV/contact Paul Goellner, MD, Northwest Medical Center, 707 Ash Street, Spooner, WI 54801; ph (715) 635-2151. p6;7-8/88

Internist with or without subspecialty interests. Board-certified or eligible to join a well-established nine man expanding multispecialty group. Location is in a southeastern Wisconsin city of 36,000 with access to a large inland lake, initial salary plus percentage as an associate. Full status in-service corporation with shared overhead and an incentive orientated formula after the first year. Please contact E.T. Ayala, MD, Department of Internal Medicine, Sharpe Clinic, SC, 92 East Division St, Fond du Lac, WI 54935; ph (414) 921-0560, collect. p6-11/88

Wisconsin, Northeastern. BC/BE Family Practice physician to join our multispecialty growing clinic in Appleton, Wisconsin. OB is optional. Guaranteed salary during the first year and an excellent benefit package with paid malpractice. The geographic region served includes the Fox River Valley, which is located in northeastern Wisconsin, and is a moderately populous, semi-urban area which prides itself on a high quality of life. Numerous outdoor recreational opportunities are readily available while two major universities, several small colleges, and active civic organizations provide cultural and educational opportunities for physicians and their families. For more information, please send your curriculum vitae or call Mr Art Schuetze, Administrator, Medical Arts Clinic, 1501 S. Madison St, Appleton, WI 54915; ph 414-730-4425. 5-7/88

Baraboo, Wisconsin. Emergency Department at St Clare Hospital seeks full and part-time physicians. Eight thousand annual visits. Hourly compensation. Pleasant area in which to live, near Devil's Lake and the Baraboo Hills. Also, Madison nearby. Contact: Mr Ronald Levy, President, St Clare Hospital, 707 14th St, Baraboo, WI 53913, ph 608/356-5561. 6-8/88

Emergency Medicine, Brainerd, Minnesota. Need BC/BE EM or FP. Join a BC/EM MD and 18 MD multispecialty clinic. Two hours from Minneapolis. Beautiful lakes and trees, ideal for families. Call collect/write Curtis J. Nielsen (218) 829-0354 or 4901. PO Box 524, Brainerd, MN 56401. 6-8/88

Family Practice partnership, Chilton, Wis, (near Sheboygan, Appleton, Fond du Lac). Ultra-modern and urban-designated hospital. Rapidly expanding practice with limited call schedule. Merely ask for informational mailing by contacting Joe Schumacher. Write Calumet Medical Center, Chilton, WI 53014; ph (414) 849-2386. p6-8/88

Physicians to take in-house call. Ideal position for residents and moonlighting physicians. Second-year residents may be suitable. Call Donna, (815) 395-5187 or write ETC, Ltd, PO Box 8034, Rockford, IL 61125. 6-8/88

BC/BE General Surgeon. Outstanding opportunity for general surgeon to associate with two active internists in a friendly rural community in northeastern Wisconsin near Green Bay. New clinic attached to a 55-bed community hospital. Excellent long-term growth potential. Send CV to Artwich Clinic, Ltd, 815 South Main St, Oconto Falls, WI 54154. p5-6/88

Family Practice, Brainerd, Minnesota. Immediate opening for seventh BC/BE FP for 18 multispecialty clinic. No capitation. Two hours from Minneapolis. Beautiful lakes and trees, ideal for families. Call collect/write Curtis J. Nielsen, (218) 829-0354 or 4901. PO Box 524, Brainerd, MN 56401. 6-8/88

Family practice. Thirty-four physician multispecialty group conveniently located between Chicago and Milwaukee. Well-equipped clinic offering salary guarantee with incentive bonus; excellent fringe benefits and early ownership. Please send current curriculum vitae to Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 4tfn/88

Physicians needed full- or part-time to perform light physicals. Milwaukee area. Professional liability provided. Phone 414/344-2100, Ms Jenkins. 10tfn/84

PHYSICIANS EXCHANGE

continued

Primary Care Physician to work in Urgent Care Department of Dean Medical Center on part-time or full-time basis. Excellent back-up services. Complete lab and x-ray on site. Attractive opportunity including guaranteed salary, profit sharing, fringe benefits, and stockholdership. Send CV to Louis C Bernhardt, MD, Chairman, Recruiting Committee, Dean Medical Center, 1313 Fish Hatchery Rd, Madison, WI 53715. Equal Opportunity/ Affirmative Action Employer. 5-6/88

MEDICAL DIRECTOR

Blue Cross & Blue Shield United of Wisconsin

Blue Cross & Blue Shield United of Wisconsin has a proud tradition of excellence. We are seeking a physician for the position of Medical Director to join our aggressive management team. We are a nationally recognized leader and offer a wide range of employee benefit products. Medical management programs range from Compcare, the state's largest HMO, to our Preferred Provider Organization and fee-for-service products with managed care.

The successful candidate for this appointment will be a physician with a strong background in Internal Medicine or General Practice, and will have demonstrated communication skills. Previous experience serving as an HMO Medical Director and knowledge of utilization review, medical review, and quality assurance is desirable.

The physician will have a vital role in planning and establishing goals and policies for our medical management departments. The physician will provide the medical expertise for all medical review activities pertaining to utilization review, quality assurance, and medical review of complex claims. This highly visible position involves contacts with the provider community on a variety of medical issues.

We offer a competitive salary and benefit package. Please reply in complete confidence to:

Plan Medical Director
Search Committee
Attention: Employment Services
Blue Cross & Blue Shield
United of Wisconsin
401 West Michigan Street
Milwaukee, Wisconsin 53203

6-7/88

Family Practice Physicians to join Dean Medical Center. Attractive practice opportunity in multispecialty clinic in and around Madison, Wisconsin. Guaranteed salary, profit sharing, excellent fringes, and stockholdership. Send CV to Louis C. Bernhardt, MD, Chairman, Recruiting Committee, Dean Medical Center, 1313 Fish Hatchery Rd, Madison, WI 53715. Equal Opportunity/ Affirmative Action Employer. 5-6/88

West Bend, Wisconsin, General Clinic, a 20-physician multispecialty group is seeking additional B/C, B/E physicians in **Family Practice, Pediatrics, OB/GYN, Internal Medicine, Urology, Dermatology,** and **ENT.** First-year salary and benefits guaranteed. Corporate association after one year. Located in a family-oriented, economically strong small city surrounded by four-season recreational and scenic Kettle Moraine area 30 miles north of metropolitan Milwaukee. Contact Hans W Schmelzling, Administrator, 279 S 17th Ave, West Bend, WI 53095; ph 414/338-1123. 7tfn/87

Great opportunity for GP/Family Physician needed to work in busy growing practice. No investment required. Established practice with guaranteed patient base. Good base salary plus incentive and potential for growth for the right doctor. Vacations and insurance paid. Reply to C H S, PO Box 641, Moline, IL 61265. 5-6/88

Family Practice physician. Challenging opportunity, Northeastern Wis; salary plus benefits, rural community health centers, hospital practice not required, tourist area, national forest. Contact Northern Health Centers, PO Box 179, Lakewood, WI 54138; ph 715-276-6321. p4-6/88

MEDICAL DIRECTOR

The University of South Dakota
(Student Health Clinic)
Vermillion, South Dakota

Responsibilities include providing patient care, medical leadership, and direct supervision of medical personnel including nurse practitioner and physician assistant. University School of Medicine appointment eligibility. Prefer internist, pediatrician or family practitioner with demonstrated interest/training in adolescent and preventive medicine. Salary is competitive with excellent fringe benefits including professional liability. This is an academic year appointment.

Send application and resume with names, addresses, and telephone numbers of three references to: Dr William Donohue, Vice President For Student Life, Room 205 Slagle Hall, 414 East Clark, Vermillion, SD 57069.

6-7/88

Pediatrician (BC/BE) to join five dynamic BC pediatricians in a 38-physician multispecialty group. Newborn stabilization skills required. Teaching environment with residents on service six out of 12 months. Cultural and outdoor recreational opportunities excellent. Send CV to Kurt Heyrman, MD, 401 North Oneida St, Appleton, WI 54911.

4-6/88

Family Practitioner. Clinic seeking a well-rounded physician to practice at a growing established satellite clinic 30 miles north of main clinic. Clinic located in a friendly rural community with year-round outdoor activities. Send CV to Artwich Clinic, Ltd, 815 South Main, Oconto Falls, WI 54154. p5-6/88

Rheumatologist—the Racine Medical Clinic a 34-physician multispecialty group conveniently located between Chicago and Milwaukee. Well equipped clinic offering salary guarantee with incentive bonus; excellent fringe benefits and early ownership. Please send curriculum vitae to: R D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 11tfn/87

Internal Medicine. Board-certified or eligible to join five general internists in a multispecialty group in northeastern Wisconsin. Office is next to two hospitals. Partnership is available after one year. Send CV to Dept 613 in care of the Journal. p4-9/88

Wisconsin. OB/GYN (BC/BE) needed to join dynamic HMO-based multispecialty group practice. University town of 55,000 near Minneapolis. Community and recreation outstanding. Competitive salary and fringes. We take pride in our patient care. Contact Robert A. Braastad, MD, Group Health Cooperative, 1030 Regis Court, Eau Claire, WI 54701; ph 715-836-8552. p5/88;6-9/88

Family Practice, Pediatrics, and Internal Medicine—Park Crest Medical Clinic in suburban Milwaukee has immediate openings in these three specialties. For more information, please contact Sherry VanErt, 2665 S Moorland Rd, New Berlin WI 53151: ph 414/786-1199. p4-7/88

Eagle River—Great opportunity for two BC/BE family practice physicians to join well-established practice. Guaranteed annual income and future partnership available. For more information, send resume to Judy Harris, Recruiter, UW Office of Rural Health, 810 University Bay Dr, Madison, WI 53705 or call collect 608/263-7933.

1tfn/88

PHYSICIANS EXCHANGE

continued

Pediatrician and **General Internist** or Family Practitioner (husband/wife team?) for multi-specialty clinic 50 miles southeast of Chicago in university town in Dunes County of southern Lake Michigan. Superior schools, many recreational opportunities, small town atmosphere. Pediatrician to join long established pediatrician with extensive practice. Four minutes from 400-bed hospital with NICU, ICU, and CCU. Contact Thomas Covey, MD, FAAP, 219-462-4167.
p5-7/88

Family Practice—Madison, Wisconsin. Eleven-year-old staff model HMO has a family practice position available. We offer a very attractive practice setting with reasonable scheduling, excellent salary and benefits. Contact: John Hansen, MD, Medical Director, Group Health Cooperative, One South Park, Madison, WI 53715; ph 608/257-9700.
4-6/88

Busy Neonatologist seeks BC/BE associate for July 1988 to share growing Level II plus private practice fee-for-service unit covering more than 4200 deliveries in southeastern Wisconsin. Reply with CV and references to Dept 618 in care of the Journal. p5-6/88

The Wausau Medical Center is seeking BE/BC individuals in the following specialties: Cardiology, Dermatology, Family Practice, Infectious Disease, Obstetrics/Gynecology, Pediatrics and Rheumatology. Modern clinic facility located across the street from modern 300-bed hospital. Full partnership in three years. Easy access to lakes, woods and mountains. Write including CV to D K Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, WI 54401. p4tfn/88

Emergency Medicine, Otolaryngologist, Urologist, and Obstetrician/Gynecologist to join multispecialty group practice in Woodruff, WI. Guaranteed annual income and excellent fringe benefit program. Send CV to R J Sloan, MD, Lakeland Medical Associates, Ltd, PO Box 549, Woodruff, WI 54568. 4tfn/88

Wonderful Opportunity. Spend the summer in beautiful northwestern Wisconsin vacationland. Family practice physician needed June, July, August to help six BCFP and one BC general surgeon with busy summer practice. Contact Paul Goellner, MD, Northwest Medical Center, 707 Ash St, Spooner, WI 54801; ph (715) 635-2151.
p6;7-8/88

BC/BE General Internist to join 26-MD multispecialty group with four internists, one nephrologist and one gastroenterologist. Top salary first year, full incentive thereafter. Central Wisconsin university town with drawing area of 80,000. Send CV to Dr John Gauder, Rice Clinic, SC, 2501 Main St, Stevens Point, WI 54481, or call collect 715/344-4120. 12tfn/87

Twenty-nine physician multispecialty clinic located in desirable East Central Wisconsin location is seeking Board-certified or Board-qualified orthopedic surgeon to round out its services. Lab, x-ray, excellent hospital. Liberal guarantee and benefits. If interested contact D F Sweet, MD, Fond du Lac Clinic, SC, 80 Sheboygan St, Fond du Lac, WI 54935.
9tfn/87

MEDICAL FACILITIES

Echocardiogram M Mode-Two Dimensional Irex machine with transducers. Best offer call (414) 342-8700. p6/88

Beloit Clinic, SC, an expanding multispecialty group in southern Wisconsin college town is seeking a pulmonologist, a gastroenterologist, and a general surgeon with vascular capabilities for its main facility, as well as a family practitioner for a satellite location. Guaranteed salary with incentive plus excellent fringe benefits. Send CV to J F Ruethling, Administrator, 1905 Huebbe Parkway, Beloit, WI 53511; ph 608/364-2200. 4-6/88

ORTHOPEDIC SURGEON
NEUROSURGEON
PHYSIATRIST
Industrial Rehabilitation

Outpatient orthopedic clinic seeking additional physicians to join growing industrial rehabilitation center specializing in disability evaluation, treatment, medical management, functional capacity assessment, work-hardening programming and employer consultation services. Part-time and full-time opportunities. Excellent guaranteed salary with incentives plus excellent fringe benefits. Please send CV to:

Bone & Joint Surgery Associates
Chiron Rehabilitation Clinic
2704 Marshall Court
Madison, Wisconsin 53705
(608) 231-3030 4-6/88

For sale or lease. Suitable for Family Practice or Internal Medicine. Excellent south side of Milwaukee location. A net income that will provide well for your family as you had always intended. This is your chance to be financially independent, be secure and at the same time be your own person. Financial request is to write your own ticket as you see it. Will introduce . . . three to six months whatever time it takes. Too good to be true? Write to VSC, PO Box 15548, Milwaukee, WI 53215. 6/88

For rent. Milwaukee, Wisconsin. Courtland Medical Center 68th and Capitol Drive. Premium physician's space available with up to nine examining rooms. Diagnostic laboratory and pharmacy on premises. Ample parking. Many incentives besides below market rates. Please contact H & H Investments at (414) 246-8029. p6/88

For Sale. Adult exam tables, pediatric exam tables with scales, x-ray machine 60 MA (Universal), x-ray machine 30 MA portable (Fischer), ICP copier, Saxon copier, office chairs, refrigerator, Unimeter, Dynaclave sterilizer, various medical instruments. Call (414) 463-0080, 9:00-5:00. p6/88.

NEW PHYSICIANS FOR WISCONSIN
is seeking
• Family Physicians • Pediatricians
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Contact: Fred Moskol
UW Office of Rural Health
810 University Bay Drive
Madison, WI 53705
608/263-7933
7-12/87; 1-6/88

The physicians on staff at Group Health, Inc. comprise one of the oldest and largest multi-specialty group practices in the Midwest. Group Health, Inc. is primarily a staff model HMO, with affiliations with a number of respected medical groups and referral specialists throughout the Twin Cities area.

If you are board certified, or board eligible, in any of the following specialties, Group Health, Inc. may have an opportunity for you.

- Adult Psychiatry
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- Ophthalmology
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For information about joining the Group Health, Inc. medical staff, call Jerry Hess at **(612) 623-8444.**

Group Health, Inc.
2829 University Avenue S.E.
Minneapolis, Minnesota 55414
3-6/88

PHYSICIANS EXCHANGE

continued

MISCELLANEOUS

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Quality Scanning for reel or cassette type recorders by qualified technicians and certified cardiologists' interpretations, scan price $35.00 with UPS speedy delivery. Recorders loaned, leased, or purchase new dual-channel Holter recorders, $750.00, with two-year warranty. For more information call Advance Medical and Research Center 1-800/552-6753. 11tfn/85

REAL ESTATE

Secluded NW Wisconsin retreat. Forty acres, 550' frontage on uninhabited 30 acre lake. Beautiful six sided, two story, three bedroom, full basement, custom modern home. Complete privacy, wildlife, and large pines. For more information write or call Buck McMinn, Chelan, WA 98816; ph 509-682-5204. p5-6/88

Spectacular Home on Loon Lake. Contemporary styled home with redwood exterior offers one or two family living. Complete two fireplaces, four spacious bedrooms, three bathrooms, screened porch, garage, boathouse and 150 feet of sandy beach plus navigable stream along one side. Year round relaxation and enjoyment. $275,000. Contact Betty at Coldwell Banker/Hilgenberg Realtors, PO Box 555, Shawano, WI 54166; ph (715) 526-6148. p6/88

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

WISCONSIN

JULY 21-23, 1988: *Wisconsin Society of Obstetrics and Gynecology,* Landmark Resort, Egg Harbor. g1-6/88

JULY 28, 1988: *Current Concepts in Trauma Care* at Paper Valley Hotel, Appleton. One-day symposium sponsored by Theda Clark Regional Medical Center and BIOMET, Warsaw, Indiana. Topics include use of trauma score, prehospital stabilization, initial emergency department management, head, chest and abdominal trauma, and emergency airway management. Faculty are nationally renowned experts in the fields of emergency medicine and traumatology: John Barrett, MD, Chicago; Howard Champion, MD, Washington; Lenworth Jacobs, MD, Connecticut; Robert Jorden, MD, Mississippi; Ron Walls, MD, Vancouver. Nominal fee. Lunch provided. Chairperson: Wendy A. Witt, MD. Information: Call (414) 729-3310 or 1-800-922-4551. p6/88

JULY 29-31, 1988: Wisconsin Dermatological American Club, Kohler. 12tfn/87

AUGUST 3-8, 1988: *"International Doctors In Alcoholics Anonymous,* Stouffer Hotel, Baltimore, MD. Info: Information Secretary, IDAA, 1950 Volney Rd, Youngstown, OH 44511; ph 216/782-6216. g1-7/88

SEPT 9-11, 1988: Wisconsin Society of Anesthesiologists, Convention Center/Embassy Suites, Green Bay. g10tfn/87

OCTOBER 1, 1988: *Wisconsin Society of Radiation Oncologists,* Concourse Hotel, Madison. 4tfn/88

OCTOBER 3-7, 1988: 54th Annual Scientific Assembly of the American College of Chest Physicians, Anaheim Convention Center, Anaheim, Calif. Info: Division of Education, American College of Chest Physicians, 911 Busse Highway, Park Ridge, IL 60068; ph 312-698-2200. g5-8/88

OCTOBER 20-21, 1988: Wisconsin Chapter, American College of Emergency Physicians, The Abbey, Lake Geneva. 2tfn/88

NOVEMBER 4, 1988: *Wisconsin Orthopaedic Society,* Olympia Resort, Oconomowoc. 4tfn/88

NOVEMBER 5, 1988: Wisconsin Allergy Society, InnTowner Hotel, Madison. Info: Robert Bush, MD, 2500 Overlook Terr, Madison, WI 53705; ph (608) 256-1909. gtfn/88

Wisconsin Specialty Society Meetings 1988

- Wisconsin Society of Obstetrics and Gynecology, July 21-23, 1988, Landmark Resort, Egg Harbor.
- Wisconsin Society of Anesthesiologists, Sept 9-11, 1988, Convention Center/Embassy Suites, Green Bay.
- Wisconsin Society of Internal Medicine, Sept 15-17, 1988, Milwaukee Marriott.
- Wisconsin Radiological Society, Sept 30-Oct 1, 1988, Concourse Hotel, Madison.
- Wisconsin Allergy Society, Nov 5, 1988, InnTowner Hotel, Madison. 6tfn/88

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THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 50¢ per word, with a minimum charge of $20.00 per listing. *All listings must be prepaid.*

BOXED LISTINGS: $25.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 15th of the month preceding the month of publication; *eg,* copy for the August issue is due by July 15. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 1-800-362-9080.

FOR LISTING of other meetings see the January 1, 1988 issue of the *Journal of the American Medical Association:* Continuing Education Opportunities for Physicians for period March 1988 through August 1988.

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AXID® 300mg

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Effective once-nightly
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nizatidine capsules

Brief Summary. Consult the package insert for prescribing information.

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients, at a reduced dosage of 150 mg h.s. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

Drug Interactions—No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported, it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Overdosage: There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LO_{50} values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

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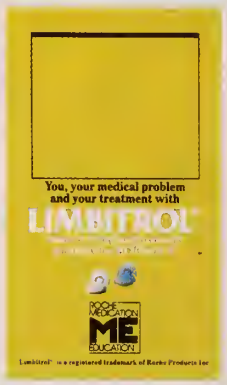

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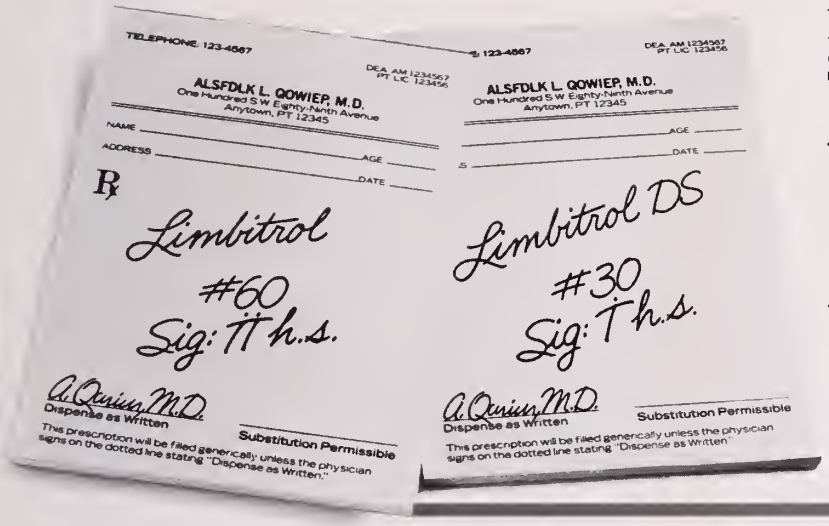

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Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.**

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. *Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. *Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. *Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. *Endocrine:* Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

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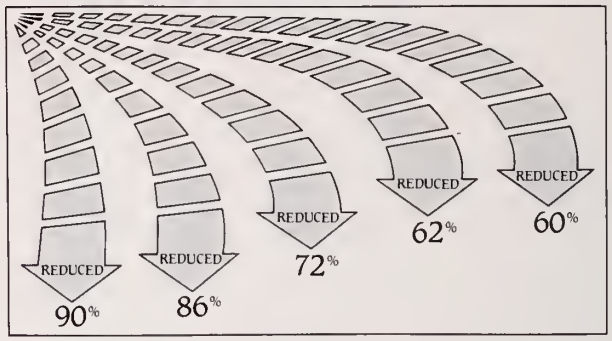

*Patients often presented with more than one somatic symptom.

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WISCONSIN MEDICAL JOURNAL

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Blue Book 1988 This special issue of the *Wisconsin Medical Journal* provides a broad view of the medicolegal, socioeconomic and legislative matters of concern to Wisconsin physicians. The Blue Book also provides a reference to the structure of the State Medical Society of Wisconsin, state government agencies and related organizations.

- Current issues in brief (see page 9).
- Medical liability: A physician's rights and responsibilities (see page 30).
- Guidelines on physician extenders in nursing homes (see page 70).
- Questions about medical records laws (see page 35).
- Communicable disease reporting laws (see page 28).
- SMS Officers and directors: 1988–1989 (see page 85).
- House actions: 1988 (see page 100).
- Awards presented at the SMS Annual Meeting (see page 118).
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- *Wisconsin Medical Journal:* July 1988 (see page 171).
- Secretary's Report: Medicare reimbursement (see page 174).

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JULY
1988

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WISCONSIN MEDICAL JOURNAL (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the editorial board, subject to policy direction of the Society's Board of Directors. The managing editor is responsible for overseeing the production, business operation, and contents of the Journal. The editorial director is responsible for editorials. Unsigned editorials express views consistent with the policies of the State Medical Society of Wisconsin. Signed editorials express personal views of the author for which the Society takes no responsibility. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus," "Hospital Literature Index," and "Cambridge Scientific Abstracts."

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THE STATE MEDICAL SOCIETY OF WISCONSIN, created by the Territorial Legislature in 1841, represents nearly 7000 member physicians in Wisconsin, comprising 55 county medical societies and 28 medical specialty sections. The purpose of the Society is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society include continuing medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, services for physicians, operation of a Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal*.

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Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the JOURNAL and are not returned. Submit one original and two carbon copies. Author should retain one carbon copy. Format and style should follow that of the *AMA Style Book and Editorial Manual.* Manuscripts are subject to editorial modification and such revisions as bring them into conformity with JOURNAL style.

Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

Under ordinary circumstances manuscripts are published about six months following acceptance, and in the order in which they are received.

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Q.

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Telephone: (608) 257-6781

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Current issues in brief—

ABORTION. Wisconsin, like several other states, has a law denying subsidies from any public source for nontherapeutic abortions except in cases in which conception results from sexual assault or incest. Laws of this nature have been subject to challenge in the courts in other states. The validity of Wisconsin's law, if challenged, cannot be predicted. In Wisconsin spousal consent for abortion is not required by law. Physicians and hospitals are granted immunity from civil liability for refusal to perform abortions. In the case of the physician this immunity is conditioned on the refusal having been based on religious or moral precepts. No hospital, school, or employer may discriminate against a physician in regard to employment, tenure, or staff privileges or status for refusal to perform abortions if this is based on religious or moral precepts.

ABUSED CHILD LAW. *Wis. Stat.* §*48.981.* Child abuse by parents and others can be found at all economic, educational, and social levels. The Wisconsin Abused Child Law was enacted to prohibit child abuse in its many forms and prevent the cumulative effect of repeated beatings or other forms of severe abuse, including sexual exploitation, physical crippling, brain damage, or even death. Intentional infliction of emotional damage to a child is also considered child abuse under the law. The Abused Child Law makes it mandatory for physicians and others dealing with children to report suspected cases of child abuse and cases in which injury is threatened and abuse likely to occur. The law further provides that the reports be made to the city police departments, sheriffs, and county child welfare agencies. Civil as well as criminal immunity from suit is granted where a report is made in good faith. For further information, refer to the special report on child abuse in the January, February, and March 1985 editions of the *Wisconsin Medical Journal.* Also see article, "Child abuse and neglect: The law—explanation and implication," which appeared in the June 1986 BLUE BOOK issue of *WMJ* on page 27.

ADOPTION PROCESS IN WISCONSIN. An *Information Memorandum,* published in the July 1982 BLUE BOOK issue of the *WMJ,* describes the process by which a potential adoptive parent adopts a child in Wisconsin. A child from Wisconsin or from another state or country may be adopted in this state with or without the services of an adoption agency. A list of adoption agencies appears elsewhere in this issue.

ADOPTION RECORDS LAW. Recent legislation in Wisconsin provides additional opportunities for adoptees and certain other persons seeking identifying information about their birth parents and information about medical and genetic history for themselves or certain other biological family. Chapter 359, Laws of Wisconsin, 1981, became effective May 7, 1982. Provisions of the law are described in an *Information Memorandum 82-25* prepared by the Wisconsin Legislative Council staff. That memorandum was published in the July 1982 BLUE BOOK issue of *WMJ* and is available upon request to the *WMJ.* The law has been amended to provide for supplying nonidentifying social history of the child's birth parents. Chapter 471, Laws of Wisconsin, 1983.

AUTOPSY. Whose consent is required to permit a physician to conduct an autopsy? Except for those cases in which an autopsy is ordered in connection with a proposed coroner's inquest permission for a physician to conduct a postmortem examination requires the consent of the person who assumes custody of the body for burial, providing that person is one of the following: father, mother, husband, wife, child, guardian, or next of kin. If none of these persons is available, consent may be given by a friend or person charged by law with the responsibility for burial. If two or more such persons assume custody of the body, the consent of either one is sufficient. Section 979.03, Wis. Stats., requires autopsies for infant death in which "sudden infant death syndrome" is suspected, unless the parents specifically object.

Sudden infant death (SID) syndrome. Section 979.03, Wis. Stats., requires autopsies for infant death in which "sudden infant death syndrome" is suspected, unless the parents specifically object.

CERTIFICATION. Wisconsin physicians are reminded that it is their responsibility, as well as to their advantage, to keep WPS-Medicare informed of any change in their specialty or certification status. To alleviate any confusion, each physician should be sure that the same specialty is shown with the various societies; *eg,* AMA, State Medical Examining Board, and the State Medical Society. There have been some instances where a different specialty was shown with each organization. Written documentation of such changes should be directed to the WPS-Medicare, PO Box 1787, Madison, WI 53701, ATTENTION-CPCU

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(Central Provider Control Unit). If you have any questions concerning the specialty WPS-Medicare currently has on file for you, contact CPCU, (608) 221-4711, ext 3420. Physicians also are urged to provide the same information to the Medicaid administrator: EDS-Federal, Attention Provider Maintenance, phone: 608/221-4746.

CHILD SEAT RESTRAINT LAW 347.48 (4) (a) *Wisconsin Statutes.* Wisconsin residents may not transport children under the age of two in motor vehicles unless the child is properly restrained in a child safety restraint system. Further, Wisconsin residents may not transport children under the age of four unless securely fastened by either a seat belt or child safety restraint. Parents are responsible for compliance if present in the vehicle, otherwise, compliance rests with the operator of the vehicle.

CLOSING A PHYSICIAN'S OFFICE. Several articles in this issue contain information that may be helpful to physicians or their spouses when closing an office: 1) "Some considerations before opening a physician's office," 2) "What to do when a physician dies," 3) "Retention and inspection of patients' records," 4) "The use of consent and related forms for physicians," and 5) "Narcotics" (what to do in case of a physician's death).

COMMUNICABLE DISEASES. The State Department of Health and Social Services reporting laws for communicable diseases is contained in Chapter HSS 145 of the Wisconsin Administrative Code. Physicians, nurses, laboratories, healthcare facilities, or any other person identifying a case or suspected case of communicable disease must report its existence to the local health officer. Further details, including a listing of reportable communicable diseases, appear elsewhere in this issue.

CONSENT AND RELATED FORMS FOR PHYSICIANS. A number of these forms which a physician may have occasion to use in his regular everyday practice appear in an article, "The use of consent and related forms for physicians," elsewhere in this issue. Related information also is included, particularly reference to sec. 448.30 Wis. Stats., relating to requiring physicians to inform their patients of alternate modes of treatment, granting rule-making authority, and creating a penalty.

"DENIAL OF ACCESS" TO HEALTHCARE RECORDS. These forms can be purchased from either of the following printers: Wisconsin Printing and Bank Supply, PO Box 637, Menomonee Falls, WI 53051 (ph 1-800-325-8094), or HC Miller Co, 224-226 East Chicago St, Milwaukee, WI 53202 (ph 1-800-242-9971). They are NOT available from the State Dept of Health and Social Services or the State Medical Society. Sample copies of the forms appear elsewhere in this issue.

DETERMINATION OF DEATH. Wisconsin law (Chapter 134, Laws of 1981) provides that 146.71 of the statutes is created to read: ***Determination of death.*** An individual who has sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death shall be made in accordance with accepted medical standards.

DISABILITY CLAIMS. Under a recent court order the Social Security Administration will review certain disability claims in Illinois, Indiana, Ohio, Michigan, Minnesota, and Wisconsin, where individuals with mental impairments were either denied disability benefits or terminated from the disability rolls. Certain individuals who were either denied social security disability benefits were terminated on or after March 1, 1981, and before January 4, 1983, who alleged a mental impairment (other than mental retardation) and who were between the ages of 18 and 49 may have their eligibility reviewed. If because of your special concerns for the mentally impaired you know of anyone who meets these requirements, the SSA of the US Department of Health and Human Services asks that you advise that person to either visit or telephone the local social security office to obtain further information. If you are representing such a person, you may contact a social security office on behalf of that person.

DONATIONS OF ORGANS, BODY. Wisconsin, along with some 40 other states, has adopted the Uniform Anatomical Gift Act, a law under which a donor may leave all or any part of his/her body for research or transplantation. With the continuing publicity given to transplant technology, physicians are being queried

continued next page

about the law and how their patients may make anatomical gifts. To assist physicians in providing the necessary information to patients, the University of Wisconsin-Madison Anatomy Department and the Medical College of Wisconsin Department of Anatomy have provided the State Medical Society with policy statements in the acceptance of bodies. These statements appeared in the June 1981 BLUE BOOK, on pages 46–47. Further information may be obtained by contacting the Medical College of Wisconsin, Department of Anatomy, 8701 Watertown Plank Road, Wauwatosa, Wis 53226, or phone 414/257-8261); or University of Wisconsin-Madison, Anatomy Department, Bardeen Medical Laboratories, 1300 University Ave, Rm 325 SMI, Madison, Wis 53706 (phone: 608/262-2888).

Uniform Organ Donor Cards and Decals. These are available from the National Kidney Foundation of Wisconsin, Inc, 6701 Seybold Rd, Madison, Wis 53719 (phone 608/274–0441), or 7332 West State St, Wauwatosa, Wis 53213 (phone 414/453–2830).

Donation of eyes. Inquiries may be directed to the Milwaukee Eye Bank, 8700 West Wisconsin Ave, Milwaukee, Wis 53226 (phone 414/257–5543), or to The Eye Bank, E5/410 Clinical Science Center, University of Wisconsin-Madison, Center for Health Sciences, 600 Highland Ave, Madison, Wis 53792 (phone 608/263–6223).

DRIVERS' LICENSES FOR EPILEPTICS. A person subject to epileptic seizures may be licensed to drive a motor vehicle in Wisconsin on a temporary basis if: (1) He or she submits with his/her application a certificate from a licensed physician recommending that a temporary driver's license be issued, and (2) He or she is otherwise qualified to obtain a license. The certificate is a form prepared by the Department of Transportation and is designed to elicit medical information necessary to determine whether permitting the epileptic to drive would be a hazard to public safety. For two years following the issuance of the license the epileptic is required to present medical certificates to the Department of Transportation at six-month intervals and yearly thereafter on the licensee's birth date until the licensee has been free of seizures for a period of 10 years from the date of issuance of the license, except that in no event is such license valid beyond the date of expiration shown on the license. On such date, the license is subject to renewal. The issuance of a temporary license is discretionary with the Department of Transportation. A denial may be reviewed, however, by a special board. Prior law had required the epileptic to file yearly medical certificates following the two-year initial period in which the epileptic was required to submit certificates at six-month intervals.

DRUG SUBSTITUTION LAW. When dispensing a prescription drug, pharmacists may either dispense the drug prescribed or, at the consumer's option, a lower cost generic to the drug prescribed. Physicians may deny generic substitution by writing on the face of the prescription order the words "no substitutions" or words of similar meaning, or the initials "N.S." It is unlawful for prescription order blanks to contain any preprinted statement regarding drug substitution. For example, check-off boxes indicating to the pharmacist "do" or "do not" substitute cannot be utilized.

ELDERLY ABUSE. Each county is now required to designate a county agency to receive reports of abuse or neglect of elder persons. Anyone may report situations in which facts or circumstances leading to a reasonable belief that an elder person (60 years or older or subject to the infirmities of aging) has been the victim of physical or financial abuse, neglect or self-neglect. Reports made in good faith are immune from civil liability. Physicians may be expected to have more opportunities than others to observe reportable facts and circumstances. Chapter 398, Laws of Wisconsin, 1983.

EMPLOYEES ALLOWED TO INSPECT RECORDS UNDER LAW. Physicians as well as other employers in the state should note the personnel records inspection law which became effective May 21, 1980. The law gives the employee the right to inspect any employer-maintained personnel records used in hiring, promoting, transfering, giving raises, or terminating that employee as well as certain medical records. The employer is required to grant the employee at least two requests to view records per calendar year, each within seven days of the request, and at a location convenient to the employee during working hours, or other agreeable arrangement. Employers may require that request in writing. An employee involved in a current grievance against the employer may designate in writing a representative, such as a union agent, to inspect the personnel records. Upon agreement of the employer and employee, any errors or differences of opinion may be noted in the record. If an agreement cannot be reached, the employee may add a written statement, to be-

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come part of the permanent file, expressing his/her opinion. The employee may also inspect any of his/her medical records that are in the employer's file. If the employer feels these medical records would be detrimental to the employee, the employer may release them to the employee's physician or the employee's immediate family. The employer may withhold some information under the law. Among the exceptions are: any records relating to possible criminal offenses, letters of reference, test documents (the employee may see the test scores), information about a third person, records relating to a pending legal claim between employer and employee, or material used by the employer for staff management planning. For complete details refer to Section 103.13, Wisconsin Statutes.

GOOD SAMARITAN LAW. The Legislature has broadened the immunity provided by the Wisconsin Good Samaritan Law to cover any person rendering aid at the scene of an emergency. First enacted to protect physicians, these laws are common throughout the United States. They are designed to encourage prompt care for persons who are injured or become ill away from normal locations where treatment is given. The scene of an emergency does not include a hospital or physician's office. Persons employed and trained to render emergency care, acting for compensation and within the scope of their employment are not protected under the law.

JAIL HEALTH CARE IN WISCONSIN. Since 1976 the State Medical Society of Wisconsin has been working with interested sheriff's departments on a *voluntary* basis to develop health care systems using the AMA's Standards for Health Services in Jails, in Juvenile Correctional Facilities, and in Prisons. Although the AMA does the accrediting of jails, the State Medical Society provides ongoing consultation which includes technical assistance emphasizing the use of existing community resources such as the county nursing service and mental health and alcoholism counselors from the Unified Services Board. Interested physicians or institutions desiring more information on what constitutes adequate care for incarcerated persons may contact the State Medical Society of Wisconsin, Attn: Jail Health Care Technical Assistance Committee, PO Box 1109, Madison, Wisconsin 53701; or phone 257-6781 (Madison area) or 1-800-362-9080 toll-free in Wisconsin.

JOINT PRACTICE: PHYSICIANS AND NURSES. Reprints of the following items are available upon request to: State Medical Society of Wisconsin, Attn: Joint Practice Committee, PO Box 1109, Madison, Wisconsin 53701; or phone 257-6781 (Madison area) or 1-800-362-9080 toll-free in Wisconsin: (1) ***Guidelines for Implementation of Joint Practice of Physicians and Nurses,*** (2) ***Statement on Joint Practice,*** and (3) ***Guidelines for Institutional Joint Practice Privileges.***

JURY DUTY. Physicians are no longer automatically exempt from serving as a juror. However, there are some qualifying circumstances under which a physician might be excused in the discretion of a judge for personal hardship or extreme inconvenience to patients. Physicians interested in further details may contact the State Medical Society of Wisconsin, PO Box 1109, Madison, Wisconsin 53701; or phone 257-6781 (Madison area) or 1-800-362-9080 toll-free in Wisconsin.

LICENSURE IN WISCONSIN. The practice of medicine and surgery within this state requires a license. Even physicians just finishing their military service, or moving to Wisconsin from another state, *must* be licensed in this state before they enter active practice. Failure to complete licensure before beginning practice may subject the physician to disciplinary action as well as criminal penalties. Temporary licenses may be granted under special circumstances by the State Medical Examining Board. Emergency treatment and consultation with licensed Wisconsin practitioners may be undertaken by physicians not licensed in this state. But, the general rule is that a physician must have a Wisconsin license to practice in this state.

LIVING WILLS—THE NATURAL DEATH ACT, Chapter 154. On October 1, 1984, Wisconsin's Natural Death Act became effective. This legislation authorizes physicians and healthcare institutions to honor patients' prospective requests regarding their treatment as evidenced by documents called "living wills" when afflicted with a terminal condition. The law sets up specific circumstances under which living wills become effective and where the documents must appear in the patient's medical records. A copy of the Declaration to Physicians and a description of the Natural Death Act as amended by 1985 Wisconsin Act 199 appears elsewhere in this issue.

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MEDIC ALERT FOUNDATION INTERNATIONAL, a nonprofit, tax-exempt organization, provides life-protecting services such as bracelets designed to alert emergency personnel to hidden medical conditions. The Medic Alert emblem is imprinted on the front side and on the back is the member's hidden medical condition along with an ID number and 24-hour emergency telephone number which can be utilized to retrieve the computerized emergency medical data within seconds. Information that is stored can include physician's telephone number, type of insurance policy, next-of-kin, blood type, medication name and dosage. Free information is available from *Medic Alert*, Turlock, California 95380.

MINOR'S CONSENT. A common question from physicians throughout the state is under what circumstances may a physician provide medical services to a minor without parental consent. As a general rule, consent for medical services to be provided to an unemancipated minor must be given by the minor's parent, guardian, or court-appointed sustaining parent. Under appropriate circumstances a court may give consent in lieu of a parent. Emancipation occurs when a minor is no longer under parental care and custody. A common example of emancipation is marriage by a minor. Wisconsin law also provides that a minor may receive diagnosis of and treatment for venereal disease, Wis. Stats. §143.07, and drug abuse, Wis. Stats. §51.47, without parental consent. Attempts to expand this law to include all medical care have failed. This area of the law, parental rights versus minors' right of privacy, is now quite active and physicians should be alert to rulings which bear on this conflict.

NEWBORN INFANT EYE DROPS. The permanent administrative rule allowing the use of either silver nitrate, tetracycline, or erythromycin for the prevention of gonococcal ophthalmia in newborn infants became effective October 1, 1980. The rule also changes the time frame in which the preventive agent must be administered after birth from "immediately" to "as soon as possible, but not later than one hour after birth." Under the rule only one child shall be treated per container.

OPENING A PHYSICIAN'S PRACTICE. Some considerations for physicians to note when opening a medical practice are outlined in an article "Some considerations before opening a physician's office" elsewhere in this issue. Physicians also are reminded that the annual BLUE BOOK issues of *WMJ* are excellent sources of information whether opening a practice for the first time or moving a practice to Wisconsin. Reprints of this year's issue, as well as previous issues, are available upon request to the *Wisconsin Medical Journal*, PO Box 1109, Madison, Wis 53701, or phone 257-6781 (Madison area) or 1-800-362-9080 toll-free in Wisconsin. Cost: $15.00 plus 5% sales tax in Wisconsin, unless tax-exempt status declared.

OPTOMETRIST REFERRAL LAW. Several publicly and privately sponsored glaucoma screening programs have inquired of the State Medical Society as to whether it is appropriate to refer persons suspected of elevated intra-ocular pressure directly to an appropriate medical specialist for further evaluation. The question arises because one section of the Wisconsin Statutes, 449.01 (3), requires any agency of the state, county, municipality, or school district to give the recipient of a vision screening program equal opportunity to choose between optometric or physician services for follow-up as a consequence of vision screening activities. At the same time, another section of the statutes, 449.19, which was passed at a later date by the Legislature, requires that an optometrist who determines the possibility of the existence of a pathologic condition to refer the person examined to an "appropriate medical specialist" for further evaluation. The State Medical Society believes that the implication of these statutes, when taken in combination, is clearly a legislative intent that whenever there is the possibility of the existence of a pathologic condition, the patient should be referred to an appropriate medical specialist for further evaluation. The Legislature's action was a recognition of the seriousness of possible pathology in the eye and the urgency and importance of referral to medical care. The Medical Society therefore feels it appropriate that a public health nurse or other person who as a result of screening tests believes there is reason to suspect glaucoma should immediately refer directly to an ophthalmologist or other appropriate medical specialist. At the same time, the Medical Society wishes to emphasize that the policy of nondiscrimination for referral to optometrists or physicians following tests for visual acuity must be respected and is encouraged.

ORGAN DONATION LAW. Since July 1, 1986 Wisconsin has had a "required request" law for organ donation. The law requires hospitals to have a system in place for making organ donation requests of family members in the event of a "suitable" donor's death. The law's intent is to address the demand for major organs (*eg,* heart, liver, kidneys) needed for transplantation; however, the request policies are applicable to other types of donations such as eyes and tissue.

continued next page

PATIENTS' RECORDS/RETENTION AND INSPECTION. Information on this subject appears in an article entitled, "Retention and inspection of patients' records," elsewhere in this issue and will not be repeated here. However, briefly stated the statute 804.10(4) reads: "Upon receipt of written authorization and consent signed by a person who has been the subject of medical care or treatment, or in case of the death of such person, signed by the personal representative or by the beneficiary of an insurance policy on the person's life, the physician or other person having custody of any medical or hospital records or reports concerning such care or treatment, shall forthwith permit the person designated in such authorization to inspect and copy such records and reports. Any person having custody of such records and reports who unreasonably refuses to comply with such authorization shall be liable to the party seeking the records or reports for the reasonable and necessary costs of enforcing the party's right to discover."

PATIENTS' RIGHT OF ACCESS TO THEIR MEDICAL RECORDS. A notice, which explains to patients the law requiring all physicians and hospitals to advise their patients of the patient's right of access to their medical record is available to Society members for posting in their offices at a place easily seen by all patients. Patients may receive information from their record upon completion of an "informed consent" release form (see copy of form in article "Retention and inspection of patients' records" elsewhere in this issue). Write: State Medical Society of Wisconsin, Attn: Communications Coordinator, PO Box 1109, Madison, Wisconsin 53701; or phone 257-6781 (Madison area) or 1-800-362-9080 toll-free in Wisconsin.

PHYSICAL THERAPY RELATING TO PRACTICE. An Attorney General's opinion, issued in April 1982 regarding two issues relating to the practice of physical therapy, fee splitting, and professional service corporation, appeared in the July 1982 BLUE BOOK issue of *WMJ* and will not be repeated here. The following is a capsule opinion: There is no violation of the "fee splitting" statute, sec. 448.08(1), Wis. Stats., where a physician, through a service corporation owned by the physician, bills the patient for his own services, and that of physical therapist employed by the corporation, provided the billing states an accurate dollar figure for the respective services. A medical professional service corporation is not in violation of sec. 180.99(2) Wis. Stats., when physical therapists are on the staff of the corporation.

PHYSICIAN'S ASSISTANTS (PA). Under Wis. Stat. §§15.08(5), 227.04, 448.40, the State Medical Examining Board governs the certification and regulation of physician's assistants. The Wisconsin Administrative Code contains specific regulatory codes regarding the physician's assistant's scope of practice, supervision by physicians, and the new prescribing rules found in Med 8.08. Under the new prescribing rules, the supervising physician may direct a PA to prepare a prescription order only if:

- —a written protocol is used and reviewed annually;
- —it is mutually determined that a PA is qualified through training and experience to prepare prescription orders as specified in the protocol;
- —when practicable, the PA consults directly with the supervising physician prior to preparing an order;
- —the order includes the supervising physician's telephone number, the PA's address; and
- —the physician either reviews and countersigns before, within one day of preparation, or reviews within 48 hours and countersigns within one week.

PAs may not prepare a prescription order for a controlled substance, as defined in §161.01(4).

PREMARITAL EXAMINATIONS. Previous statutes requiring couples to have premarital (VD screening) examinations have been repealed. The physician's practice of giving complete physical examinations or representing complete physical examinations is no longer a mandatory requirement of the statutes.

STANDARD CASUALTY MEDICAL REPORT FORM. In 1963 the State Medical Society of Wisconsin and the Wisconsin Claims Council developed an agreement whereby a doctor who files a standard short report form without charge receives insurance company support of his or her financial interest at the time of payment. The casualty companies and the State Medical Society devised the form to protect the interests of doctors, companies, and insureds. Because it is the standard report form recognized by the Society, it cannot be changed by any insuror other than to add the logo of the insurance company requesting the information. Physicians are cautioned that this agreement only applies to the short form. If a physician is asked to file a lengthy narrative report by the insurance company, he or she should expect payment for this additional service. Physicians usually get these forms from the insurance company involved. ■

Acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus* (HIV)

PHYSICIANS AND OTHERS in the medical community who provide care to persons* whose sexual or needle-sharing behaviors place them at increased risk for acquiring an HIV infection should be aware of the organizations and agencies that provide information, counseling, testing and referral for these individuals. Individuals who could benefit from these services include persons with AIDS, persons infected but asymptomatic, uninfected persons who are concerned about their past high risk behaviors (worried well), and persons concerned about a family member or friend in one of the previously mentioned high risk groups.

Following is a list of organizations that provide information, support and referral for counseling, testing and medical services to persons at increased risk of HIV infection:

Wisconsin Division of Health . . 608-267-5287
Wisconsin AIDS Hotline 1-800-334-AIDS
Monday–Friday 9 AM–9 PM
Milwaukee AIDS Project 414-273-AIDS
Blue Bus Clinic (Madison) 608-272-7440
24-hour tape 272-7330
Madison AIDS Support
Network 608-255-1711
Center Project, Inc
(Green Bay) 414-437-7400
Among Friends (Rural Gays) . . . 608-244-3281
The United (Madison) 608-255-8582
The Gay and Lesbian
Resource Center (Madison) . . . 608-257-7575
Parents and Friends
of Gays (Madison) 608-267-7575
24 hour line 251-1126
(Milwaukee) 414-931-7727

Persons at increased risk of infection with HIV

Gay or bisexual men account for 70 percent of the reported AIDS cases nationwide, and in Wisconsin they account for 78 percent of the AIDS cases reported to the DOH. Educational materials and organized programs to disseminate information about AIDS and HIV infection have been developed by the Division of Health, gay affiliated organizations and AIDS service groups. Consequently, homosexual men who acknowledge their risk of infection and who have access to this material are generally well-informed about methods to prevent acquisition or transmission of infection. In contrast, some men who engage in homosexual activities may consider themselves to be heterosexual. Others may be poorly informed about AIDS and HIV transmission. Individuals in these groups may continue to engage in high risk behaviors that permit HIV transmission.

Many homosexually active men believe that they do not need to be tested for antibody to HIV in order to reduce their risk of infection or transmission to another person. These individuals argue that the potential for discrimination or loss of confidentiality outweighs the benefit of testing. Instead they prefer to rely on behavioral changes to reduce their risk of HIV transmission or acquisition. Confidential HIV antibody testing of high risk individuals in conjunction with risk reduction counseling may have a considerable influence on motivating individuals to change high risk behaviors.

In an effort to provide persons at risk of HIV infection with accessible, anonymous, inexpensive or free HIV antibody testing the Division of Health has established a network of counseling and testing sites. Counselors at the sites have received specific training to provide clients with information, targeted risk reduction messages and when appropriate, prompt referral to medical and mental health care providers.

Physicians and other health care providers should discuss HIV antibody testing with all patients who may have been infected through sexual contact or needle-sharing.

Most physicians will order HIV antibody tests and provide counseling for their own patients. This facilitates continuity of care and provides for immediate medical evaluation and follow up.

On rare occasions a clinician may refer a patient to a Division of Health site for antibody counseling and testing. Referral to a DOH site is appropriate for patients who are particularly concerned about the cost of testing or confidentiality of test results.

IV drug users are at increased risk for infection with HIV as a result of sharing needles and syringes used to inject illicit drugs. Studies conducted in New York and New Jersey indicate that IV drug users who are drug dependent are unlikely to significantly modify their drug using practices without the assistance of substance abuse counselors in a drug treatment program. Nationally 17 percent of the reported AIDS cases have been in IV drug users who have no other risk factors; and additional 8 percent occurred in those who reported homosexual contact and IV drug use. Secondary spread of HIV from IV drug users occurs through sexual transmission or by perinatal transmission to infants.

Health care providers who identify IV drug use in

*The virus associated with acquired immunodeficiency syndrome (AIDS) has been variously termed human T-lymphotropic virus type III (HTLV-III), lymphadenopathy-associated virus (LAV), AIDS-associated retrovirus (ARV), or human immunodeficiency virus (HIV). The designation human immunodeficiency virus (HIV) has recently been proposed by a subcommittee of the International Committee for the Taxonomy of Viruses as the appropriate name for the retrovirus that has been implicated as the causative agent of AIDS.

their patients should strongly encourage them to seek treatment and provide them with referral to an appropriate residential or outpatient drug/alcohol treatment facility. In addition, care providers who perceive that a patient may have an alcohol or non-injecting drug dependency should recognize that often use of these substances may impair judgment and ability to make sound decisions regarding the avoidance of unsafe sexual practices. Physicians should also evaluate the appropriateness of referring these patients into substance abuse centers. Patients who use IV drugs as well as those who use non IV drugs should be counseled and assessed to determine the appropriateness of HIV antibody testing.

Physicians and other primary care providers should work with local public health agencies, Division of Health HIV counseling and testing sites and substance abuse treatment center staff to develop appropriate referral lists for patients they identify to be in need of substance abuse treatment and counseling and HIV counseling and testing.

The following are examples of residential and outpatient drug and alcohol treatment facilities which offer information, counseling, treatment, and referral to persons who are at risk for HIV infections as a result of needle sharing practices.

PICADA (Madison) . . . . . 608-255-0819 or 251-4558

Tellurian Community, Inc (Madison) 608-222-7311

Eau Claire County Guidance Clinic 715-832-3471

New Beginning Clinic (Milwaukee) 414-643-8530

Fourth Street Program (Milwaukee) 414-271-2512

St Anthony's Hospital (Milwaukee) 414-271-1965

For additional information on drug abuse counseling call your local public health agency or the substance abuse treatment center in your community.

Persons with hemophilia and other blood coagulation disorders who used blood products prior to the initiation of heat treatment are at risk for infection with HIV. Approximately 50–60 percent of persons with hemophilia in the United States receive medical care through hemophilia treatment centers or from a hematologist. Information, counseling and referral for persons with hemophilia and their family members or significant others are available from the Comprehensive Hemophilia Centers at the following locations:

Sacred Heart Hospital (Eau Claire) 715-839-4404 839-4418

St Vincent's Hospital (Green Bay) 414-433-8213

Webster Clinic (Green Bay) 414-437-0431

University of Wisconsin Clinical Science Center (Madison) 608-263-1836

American Red Cross (Madison) 608-233-9300

Great Lakes Hemophilia Foundation (Milwaukee) 414-344-0772

Physicians or other health care providers working with hemophilia patients who identify sexual partners wishing to obtain anonymous testing should provide referral to Division of Health HIV counseling and testing sites.

Some persons will, when HIV infection is identified, experience considerable concern and anxiety. Individuals who indicate either verbally or through their actions that they are unable to cope with a positive antibody test result should be promptly referred to a mental health professional for additional evaluation and counseling. Physicians and other health care providers are encouraged to develop appropriate mental health referral sources to deal with crisis situations as well as psychological evaluation and supportive counseling.

Physicians and other health care professionals should be aware of the support services available within their community. The local public health agency can be a valuable source of information and assistance in developing or identifying available social and supportive services such as hospice, home health care, nursing homes, etc. In addition, in many communities the local public health agency staff will either provide AIDS/HIV inservices to a variety of audiences (e.g., community groups, law enforcement, businesses and schools), or identify appropriate speakers for inservices.

The Division of Health coordinates a network of 31 HIV antibody testing and counseling sites (alternate testing sites) throughout the state. Most of the alternate sites provide anonymous and free information, counseling, testing and referral for persons in high risk groups. When persons who desire counseling and testing call a site to make an appointment they should inquire about the site's policy on anonymity. The following is a list of the alternate testing sites.

Counseling the AIDS Patient Tape available for loan

A tape entitled, "Counseling the AIDS Patient," prepared by the Los Angeles County Medical Society, is available for loan from the State Medical Society of Wisconsin at 1-800-362-9080.

Alternate testing sites

			Anonymous/Free
Southeast			
Brady East STD Clinic 1240 E Brady St	414-272-2144 414-273-2437	Milwaukee	Yes/Yes
Herpes Health Center St Anthony's Hospital 1004 N 10th St	414-271-1965 ext 754	Milwaukee	Yes/Yes
Marquette University Student Health Services Schroeder Complex	414-224-7184	Milwaukee	No/Yes
Milwaukee Health Department 841 N Broadway	414-278-3621	Milwaukee	Yes/Yes
Sixteenth Street Community Clinic 1036 S 16th St	414-672-1353	Milwaukee	Yes/Sliding Fee
UW-Milwaukee Student Health Services University of Wisconsin-Milwaukee Norris Health Center, Box 413	414-963-4716	Milwaukee	Yes/Yes
West Allis Health Department STD Clinic, 7120 W National	414-476-3770 ext 423	West Allis	Yes/Yes
Waukesha County Health Department 325 E Broadway	414-549-3012	Waukesha	Yes/Yes
City of Kenosha Health Department 625 52nd St	414-656-8170	Kenosha	Yes/Yes
Racine Health Department 730 Washington Ave	414-636-9498	Racine	Yes/Yes
Sheboygan City Health Department City Hall Annex 709 N 7th St	414-459-3485	Sheboygan	Yes/Yes
South central and southwest			
Beloit Stateline Clinic 539 Blackhawk Blvd	815-389-3583	South Beloit	Yes/Yes
Beloit Student Health Services Beloit College	608-365-3391 ext 331	Beloit	Yes/Beloit (students only)
Blue Bus Clinic 1552 University Ave	608-262-7330	Madison	Yes/Yes
Madison Department of Public Health 1954 E Washington Ave	608-246-4516 608-246-HTLV	Madison	Yes/Yes
Northeast Family Medical Center 3209 Dryden Drive	608-241-9020	Madison	Yes/Yes
Wingra Family Practice Clinic 777 S Mills St	608-263-3111	Madison	Yes/Yes
Verona Family Practice Clinic 524 W Verona Ave	608-845-9531	Verona	Yes/Yes
Grant County Public Health Nursing Service Courthouse	608-723-6416	Lancaster	Yes/Yes
UW-Platteville Student Health Services 725 W Main St	608-342-1891	Platteville	Yes/Yes
Northeast			
Fond du Lac County Public Health Nursing Service 160 S Macy St	414-929-3290	Fond du Lac	Yes/Yes

UW-Oshkosh Student Health Services 777 Algoma Blvd	414-424-2424	Oshkosh	Yes/Yes
Winnebago County Public Health Department 725 Butler Ave	414-235-5100 414-725-2653	Winnebago	Yes/Yes
Center Project, Inc 513 S Broadway	414-437-7400	Green Bay	Yes/Yes
North-central			
Oneida County Nursing Services Courthouse	715-369-6111	Rhinelander	Yes/Yes
Portage County Community Human Services Department 817 Whiting Ave	715-345-5350	Stevens Point	Yes/Sliding fee
UW-Stevens Point Student Health Services Delzell Hall	715-346-4646	Stevens Point	Yes/Yes
Northwest			
UW-La Crosse Student Health Services 1725 State St	608-785-8559	La Crosse	Yes/Yes
La Crosse Health Department STD Clinic, Grandview Building 1707 Main St	608-785-9723	La Crosse	Yes/Yes
UW-River Falls Student Health Services 409 Spruce St	715-425-3292	River Falls	Yes/Yes

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AMA Policy statement on refusal to treat AIDS patients

In 1987, the American Medical Association's Council on Ethical and Judicial Affairs concluded that "a physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive (to the AIDS antibody)."

The AMA report, entitled "Ethical issues involved in the growing AIDS crisis," said, "The tradition of the American Medical Association, since its organization in 1847, is that: 'when an epidemic prevails, a physician must continue his labors without regard to the risk of his own health.'

". . . AIDS patients are entitled to competent medical service with compassion and respect for human dignity and to the safeguard of their confidences within the constraints of the law. Those persons who are afflicted with the disease or who are seropositive have the right to be free from discrimination."

The Council's new opinion on physicians and infectious disease is: "A physician who knows that he or she has an infectious disease should not engage in any activity that creates a risk of transmission of the disease to others."

Briefly, statements adopted by the council, include:

- Physicians are dedicated to providing competent medical service with compassion and respect for human dignity.
- Physicians who are unable to provide the services required by AIDS patients should make referrals to those physicians or facilities equipped to provide such services.
- Physicians are ethically obligated to respect the rights of privacy and of confidentiality of AIDS patients and seropositive individuals.
- Where there is no statute that mandates or prohibits the reporting of seropositive individuals to public health authorities and a physician knows that a seropositive individual is endangering a third party, the physician should: attempt to persuade the infected patient to cease endangering the third party; if persuasion fails, notify authorities; and, if the authorities take no action, notify the endangered third party.
- A physician who has AIDS or who is seropositive should consult colleagues as to which activities the physician can pursue without creating a risk to patients.

SMS members should be aware that Wisconsin has a comprehensive statute regarding AIDS and HIV antibody testing and reporting which allows physicians to disclose the results of tests for the presence of an antibody to HIV to the state epidemiologist of his or her designee for the purpose of providing epidemiologic surveillance or investigation and con-

trol of communicable disease. Wisconsin statutes also provide for civil or criminal penalties against individuals who disclose these test results in violation of state statutes.

A complete explanation of AIDS and HIV antibody testing and reporting requirements in Wisconsin can be found on pages 20–21 of this issue of the *Wisconsin Medical Journal.*

SMS member physicians interested in obtaining a copy of the report of the Council on Ethics and Judicial Affairs may contact the SMS Division of Communications at 1-800-362-9080.■

AIDS and HIV antibody testing and reporting

State law adopted in late 1985 created the requirement that written consent be obtained from any person undergoing a test for presence of HIV antibody. This law also placed strict prohibitions on the disclosure of HIV antibody test results. In late 1987, additional legislation (1987 Wisconsin Act 70) regulating testing and disclosure of test results was adopted by Wisconsin's legislature. The provisions of current Wisconsin law regarding HIV antibody testing and reporting are summarized below.

1. Written consent for testing

In most cases you must have a signed consent form before you can perform an HIV antibody test. The consent form must include in it the test subject's name; a statement that test results may be disclosed as specified in the statutes, along with a listing of the persons to whom disclosure may be made according to the statute, or a statement that the listing is available upon request; and a space for the person's signature and date signed. The consent form may also include permission to disclose test results to persons other than those specified in the statute. If so, the form must state the name of the person(s) to whom disclosure may be made and the time period during which the consent to disclosure is effective.

2. Who gives consent?

The law specifies that the subject of the test must give his or her written consent for testing.

3. Exceptions to consent requirement

The subject's written consent for testing is not required in the following situations:

- When a health care provider testing to determine the medical acceptability of an organ donation or donation of any other body part. Testing for the presence of HIV or HIV antibody is now mandatory not only for blood and blood products but also for all donated human body parts or human tissue, sperm or ova. If the test is positive, the donated blood, organ tissue, sperm or ova may not be used.
- When health care providers, blood banks and blood and plasma centers, certified laboratories, and the Department of Health and Social Services are testing for research purposes, and when the subject's identity is not known and may not be retrieved by the researcher. (Other provisions apply to research activities when a subject has given consent to testing; see below).
- Where an emergency caregiver has been significantly exposed and the emergency or accident victim dies prior to HIV testing; where a health care provider or providers agent or employee is significantly exposed to a corpse or to a patient who dies prior to HIV testing; or where a funeral director, coroner, medical examiner, their assistants or persons performing or assisting in performing an autopsy are significantly exposed to the corpse, assuming that a physician has certified that the exposure met the criteria of "significant."

4. Disclosure of test results without patient's consent

Once an HIV test is performed, the law specifies who may receive information regarding the test results without the patient's further consent. (The law relates to disclosure of test results, not disclosure of the fact that a test was done. Thus, a health insurer may be billed for the cost of doing the test, which de facto discloses that a test was done, without stating whether the test findings were positive or negative. Some laboratories, however, may require patient consent before billing an insurer, or give the patient the option of paying for the test directly.)

Test results may be disclosed to the following persons without patient consent specifically for disclosure:

- to the subject of the test himself or herself;
- to the test subject's health care provider (including physicians, dentists, nurses, optometrists, and others defined in Wis. Stats. 146.81(1), and including those instances where a health care provider provides emergency care to a patient;
- to employees or agents (of the subject's health care provider) who provide patient care or handle or process specimens of bodily fluids or tissues;
- to a blood bank or blood and plasma center performing the HIV test, for the purposes of determining the medical acceptability of the blood or plasma; notifying the test subject of the test results; or investigating HIV infections in blood or plasma;
- to a health care provider involved in organ donation, for the purpose of assuring medical acceptability of the gift;

- to the state epidemiologist or his or her designee;
- to a funeral director or other person preparing a body for burial or other disposition;
- to emergency caregivers, coroners, medical examiners and their appointed assistants, funeral directors and persons performing or assisting in autopsies who have sustained a significant exposure ("significantly exposed" means that the persons sustained a contact which carries the potential for transmission of HIV by one or more of the following: transmission of blood, semen, or other body fluids into a body orifice; exchange of blood during the accidental or intentional infliction of a penetrating wound, including a needle puncture; blood or other body fluid exchange into an eye, an open wound, an oozing lesion, or where a significant breakdown in the epidermal barrier has occurred; exposition to saliva as a result of a bite during the course of which the skin is broken; the provision of cardiopulmonary resuscitation; other routes of exposure defined as significant in rules promulgated by DHSS). A disclosure of test results without patient consent under these sections of the statutes requires a physician's certification based on information provided by the person that the exposure was significant as defined above;
- an individual's attending physician may (but is not required to) disclose the test results if positive and the individual is deceased that information to persons with whom the individual has had sexual contact or has shared intravenous drug use paraphernalia;
- test results may be disclosed if the possible HIV status is relevant to the cause of death of a person whose death is under direct investigation by the coroner, medical examiner, or appointed assistant; and
- test results may be disclosed in order to permit assigning a prisoner with a positive test result to a private cell to a sheriff, jailer, keeper of a prison, jail or house of correction or person designated with custodial authority by the sheriff, jailer or keeper of the facility.

(SAMPLE)

CONSENT TO HIV ANTIBODY TESTING

I, _____, authorize _____
(patient's name) (physician, clinic, etc)
to perform or arrange for the performance of a test or series of tests for the presence of HIV antibody. I understand that test results may not be disclosed without my written consent, except as specifically provided by state statute.*

_____ _____
PATIENT'S SIGNATURE DATE

THIS FORM IS NOT VALID UNLESS SIGNED AND DATED.

**Optional:* CONSENT TO DISCLOSURE OF HIV ANTIBODY TEST RESULTS

I authorize _____ to disclose HIV
(physician, clinic, etc)
antibody test results to the following persons or entities, for the time periods shown:

_____ Beginning: _____ Ending: _____
(Name of person to whom disclosure may be made.) (Date) (Date)

_____ Beginning: _____ Ending: _____
(Name of person to whom disclosure may be made.) (Date) Date)

_____ _____
PATIENT'S SIGNATURE DATE

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*Wisconsin Statutes (s.146.025) provide that HIV antibody test results may not be disclosed without written consent, except that test results may be disclosed to certain persons such as your health care providers, approved researchers and health care reviewers, and the state epidemiologist. A listing of the persons to whom disclosure may be made appears on the reverse of this form.

**Wisconsin statutes provide that the person who is the subject of an HIV antibody test may authorize disclosure of the test results to any person or entity by completing a form with the information included in this section. Such a form may be completed with the initial consent to testing, or as a separate form at any time subsequent to the testing.

Language regarding access to test results of physicians and other health care workers is clarified to assure that test results may be provided without specific patient consent to any health care provider who provides care to the person tested including emergency care (not just the patient's primary physician); to agents or employees of health care providers who provide patient care, handle or process specimens of body fluids or tissues, or prepare or store patient health care records; and to persons who perform or assist in performing an autopsy.

Test results may also be disclosed under the following circumstances which parallel the general statutes authorizing disclosure of medical records:

A. Under a lawful order of a court of record.
B. To a researcher, for research purposes, if the researcher:
   1. is affiliated with the subject's health care providers;
   2. has obtained permission to perform the research from an institutional review board; and
   3. provides written assurance to the person disclosing the test results (not necessarily the test subject) that use of the information is only for the research purpose, the information will not be released to a person not connected with the study, and the final research project will

not reveal patient-identifying information unless the researcher receives written consent from the patient.

A private pay patient may deny access to test results under this research provision by annually submitting a signed, written request to the person maintaining test results.

C. To health care facility staff committees or accreditation or health care services review organizations, for the purposes of conducting program monitoring and evaluation and health care services reviews.

5. Disclosure of test results with patient's consent

Test results may be disclosed to anyone specified by the test subject or patient, with the subject's written consent. Such written consent to disclose test results may be given at the time, and on the same form as, the subject gives written consent to have the test performed. It may also be given on a separate form at any time subsequent to the test. The form must include the name of the person(s) to whom disclosure may be made, the time period during which the consent to disclosure (beginning and end) is effective, and the date on which the consent to disclosure is signed.

6. Inclusion in medical records

Test results may be included in the medical record. They must, however, remain confidential, with disclosure allowed only as provided above. Note that several of the provisions for disclosure without patient consent, described under item no. 4, are identical to statutory provisions on disclosure without consent of a medical record or parts thereof. There are several statutory provisions allowing disclosure of medical records in general which are not repeated in the statutes regarding HIV test disclosure. Care should be taken that HIV test results are not inadvertently disclosed under these circumstances:

A. Disclosure in response to a written request from a federal or state governmental agency. (Keep in mind that there is a specific exception for reporting positive test results to the state epidemiologist.)
B. Disclosure to county agency investigating elder abuse.
C. Disclosure to the extent that records are needed for billing, collection or payment of claims. (Keep in mind that "disclosure" refers to disclosure of test results, not disclosure of the fact that a test was done.)
D. For medical records generally, the statutory wording on access to medical records by other health care providers and persons under their supervision is slightly different than the wording which specifically discusses provider access to test information, described under item no. 4.

(Some have argued that medical records personnel are not covered by the statute referencing persons providing "patient care," and thus may not have statute referencing persons providing "patient care," and thus may not have access to test results without patient consent. However, Assembly Health Committee records and correspondence from Health Committee chair Rep John Robinson clearly state that it is the legislative intent to include medical records personnel among those having access to test results for purposes of performing their job functions.)

State law was modified in late 1987 to note that pupil health records and ambulance run records relating to administration of care, patient names, medical history, and condition will be treated as patient health care records and kept confidential.

7. Reporting to state epidemiologist

All validated positive HIV antibody test results are to be reported to the state epidemiologist. The state epidemiologist defines what constitutes a "validated positive" test. The report is to include:

- the name and address of the health care provider reporting;
- if known, the name and address of the test subject's health care provider;
- if known, the test subject's name, address, phone number, age or date of birth, sex, race and ethnicity, and county of residence;
- the date on which the test(s) were performed and the results; and
- other information which the state epidemiologist may require.

If a report of a positive HIV test is made and the test subject has not yet been diagnosed with AIDS, the report may not include information on the test subject's sexual orientation or the identity of persons with whom he or she may have had sexual contact. This provision does not apply when a confirmed AIDS diagnosis, including antibody test results, is reported pursuant to the communicable disease statute reporting requirements.

8. Penalties for unlawful testing or disclosure

Disclosure of test results in violation of state statutes may bring civil or criminal penalties. Persons to whom information is legally disclosed are bound by the same restrictions as the persons originally having access to test results.

The penalty for performing a test without written consent (except as provided above), unlawfully disclosing test results, or (with positive tests) reporting sexual orientation or sexual contacts to the state in the absence of an AIDS diagnosis, is a fine of up to $1,000 for a negligent violation and up to $5,000 for an intentional violation, plus the subject's actual damages and costs.

If test results are "intentionally disclosed" by someone in violation of subject of the test, "a criminal penalty may be levied of up to a $10,000 fine or nine months imprisonment or both."■

More AIDS information available

The Division of Health maintains a variety of materials available to health care professionals which are available from the Division of Health in limited quantities upon request. These include:

Information for health care providers

Announcement: Primary and second level testing for HTLV-III antibody. State Laboratory of Hygiene (March 1985).

Clinicians' guide to evaluation of HTLV-III antibody positive individuals. Division of Health (March 1985).

Providing pretesting information about HTLV-III antibody testing. Division of Health (May 1986).

Counseling people with seronegative HTLV-III antibody test results. Division of Health (May 1986).

Counseling people with seropositive HTLV-III antibody test results. Division of Health (May 1986).

AIDS Task Force recommendations, State Medical Society of Wisconsin (available from SMS).

Information for Patients

AIDS: Protect your health, know the facts. Brochure, Division of Health. Available in quantities of 25.

AIDS brochure in Spanish. Available in quantities of 10.

The National Hemophilia Foundation AIDS and hemophilia: Your questions answered. (March 1985).

Hemophilia and AIDS: Intimacy and sexual behavior (September 1985).

Questions and answers about the HTLV-III antibody test. Division of Health (July 1985).

Information for individuals about the test for antibodies to the HTLV-III virus. Division of Health (March 1985).

Advice for AIDS patients. Daily living recommendations for persons with AIDS. Division of Health (February 1985).

Organizations providing service to persons at risk for AIDS. Division of Health (August 1985).

Applying for Social Security benefits: The basic facts for persons with acquired immunodeficiency syndrome. Division of Health (October 1985).

Order forms for "Living with AIDS: A self care manual" for persons with AIDS. A 95-page publication by the AIDS Project Los Angeles (October 1985).

Epidemiology

Peterman T, Drotman D, Curran J: Epidemiology of the acquired immunodeficiency syndrome (AIDS). *Epidemiologic Reviews* 1985;7:1–21.

Curran J, Morgan W, Hardy A, et al: The epidemiology of AIDS: Current status and future prospects. *Science* 1985;229:1352–1357.

AIDS and HIV surveillance

The case definition of AIDS used by the CDC for national reporting. Centers for Disease Control (August 1985).

AIDS Case and HTLV-III/HIV antibody test reporting requirements (June 1986).

Confirmed acquired immunodeficiency syndrome (AIDS) case report form (DOH 4264). Division of Health.

Positive HTLV-III/HIV antibody test case report form (DOH 4338). Division of Health.

AIDS surveillance report (quarterly). Wisconsin Division of Health.

Wisconsin alternate HIV counseling and testing site data. Wisconsin Division of Health *Quarterly Report.*

Infection control recommendations

Martin L, McDougal J, Loskoski S: Disinfection and inactivation of the human T-cell lymphotropic virus type III/lymphadenopathy-associated virus. *Journal of Infectious Diseases* 1985;152:400–403.

AIDS inpatient infection recommendations and precautions. Division of Health (June 1985).

Infection precautions for people with AIDS and for persons providing direct care to persons with AIDS living in the community. Division of Health (October 1985).

Facts about AIDS for dental professionals. Council on Dental Professionals. American Dental Association (October 1985).

AIDS Task Force recommendations, State Medical Society of Wisconsin (available from SMS).

AIDS, HTLV-III and HIV related legislation

1985 Wisconsin Act 73

- ss. 103.15—Restrictions on use of a test for antibody to HTLV-III,
- ss. 146.025—Confidentiality of the test results and informed consent,
- ss. 146.025 (7)—Reporting positive validated test results.

Summary of Act 73. Division of Health.

1987 Wisconsin Act 70.

Special issues on AIDS. Wisconsin Medical Society *Medigram* (December 1985).

Sample consent forms for HTLV-III antibody testing.

Morbidity and mortality weekly reports (Centers for Disease Control)

Immunization of children infected with human T-lymphotropic virus type III/lymphadenopathy-associated virus. *MMWR* 1986;35:595–598;603–606.

Human T-lymphotropic virus type III lymphadenopathy-associated virus: agent summary statement. *MMWR* 1986;35:540–542;547–549.

Diagnosis and management of mycobacterial infection and disease in persons with HTLV-III/LAV infection. *MMWR* 1986;35:448-452.
Safety of therapeutic immune globulin preparations with respect to transmission of HTLV-III/LAV. *MMWR* 1986;35:231-233.
Recommendations for preventing transmission of infection with HTLV-III/LAV during invasive procedures. *MMWR* 1986;35:221-223.
Additional recommendations to reduce sexual and drug abuse transmission of HTLV-III/LAV. *MMWR* 1986;35:152-155.
Apparent transmission of HTLV-III/LAV from a child to a mother providing health care. *MMWR* 1986;35:76-79.
Tuberculosis—US 1985 and the possible impact of HTLV-III/LAV. *MMWR* 1986;35:74-76.
Recommendations for assisting in the prevention of perinatal transmission of HTLV-III/LAV and AIDS. *MMWR* 1985;34:721-732.
Summary: Recommendations for preventing transmission of infection with HTLV-III/LAV in the workplace. *MMWR* 1985;34:681-690.
Update: Evaluation of HTLV-III/LAV in health care personnel—US. *MMWR* 1985;34:575-578.
Heterosexual transmission of HTLV-III/LAV. *MMWR* 1985;34:561-562.
Acquired immunodeficiency syndrome (AIDS): precautions for clinical and laboratory staff. *MMWR* 1982;31:577-580.
Human T-lymphotropic virus type III/lymphadenopathy-associated virus antibody testing at alternate sites. *MMWR* 1986;35:284-287.
Classification system for human T-lymphotropic virus type III/lymphadenopathy-associated virus infections. *MMWR* 1986;35:334-339.

Wisconsin Public Health Task Force on AIDS

The Task Force has taken action on guidelines for prevention of transmission of HIV infection in a variety of settings and circumstances including:

- Schools
- Prisons
- Nursing homes
- Hospitals
- Work place
- Home care
- Post-mortem
- Child care
- Dental
- Division of care and treatment facilities
- Health care for the chronically ill
- Neuropsychiatric aspects of AIDS
- Emergency medical service
- Professional and public education
- Contact notification
- Serologic screening
- Task force summary report.

Request for materials should be directed to the: AIDS/HIV Infection Program, Wisconsin Division of Health, 1 West Wilson, PO Box 309, Madison, WI 53701-0309 (telephone: 608-267-5287).■

FORT CRAWFORD MEDICAL MUSEUM
PRAIRIE DU CHIEN, WISCONSIN

Open daily May 1 through October 31
10 a.m. to 5 p.m.
Adults $2 Children $.50

Three building complex owned by the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin

Wisconsin Administrative Code

MEDICAL EXAMINING BOARD

Chapter Med 18

ALTERNATE MODES OF TREATMENT

Med 18.01 Authority, purpose and scope
Med 18.02 Definitions
Med 18.03 Communication of alternate modes of treatment
Med 18.04 Exceptions to communication of alternate modes of treatment
Med 18.05 Recordkeeping

Med 18.01 Authority, purpose and scope. (1) AUTHORITY. The rules in this chapter are adopted pursuant to authority in ss. 15.08 (5)(b), 227.014, and 448.40, Stats.

(2) PURPOSE. The purpose of the rules is to define the obligation of a physician to communicate alternate modes of treatment to a patient.

(3) SCOPE. The scope of the rules pertain to medical and surgical procedures which may be prescribed and performed only by a physician, as defined in s. 448.01 (5), Stats.

Med 18.02 Definitions. (1) "Emergency" means a circumstance in which there is an immediate risk to a patient's life, body part or function which demands prompt action by a physician.

(2) "Experimental treatment" means a mode of treatment which has not been generally adopted by the medical profession.

(3) "Viable" as used in s. 448.30, Stats., to modify the term, "medical modes of treatment" means modes of treatment generally considered by the medical profession to be within the scope of current, acceptable standards of care.

Med 18.03 Communication of alternate modes of treatment. (1) It is the obligation of a physician to communicate alternate viable modes of treatment to a patient. The communication shall include the nature of the recommended treatment, alternate viable treatments, and risks or complications of the proposed treatment, sufficient to allow the patient to make a prudent decision. In the communication with a patient, a physician shall take into consideration:

(a) A patient's ability to understand the information;

(b) The emotional state of a patient; and,

(c) The physical state of a patient.

(2) Nothing in sub. (1) shall be construed as preventing or limiting a physician in recommending a mode of treatment which is in his or her judgment the best treatment for a patient.

Med 18.04 Exceptions to communication of alternate modes of treatment. (1) A physician is not required to explain each procedural or prescriptive alternative inherent to a particular mode of treatment.

(2) In an emergency, a physician is not required to communicate alternate modes of treatment to a patient if failure to provide immediate treatment would be more harmful to a patient than immediate treatment.

(3) A physician is not required to communicate any mode of treatment which is not viable or which is experimental.

(4) A physician may not be held responsible for failure to inform a patient of a possible complication or benefit not generally known to reasonably well-qualified physicians in a similar medical classification.

(5) A physician may simplify or omit communication of viable modes of treatment if the communication would unduly confuse or frighten a patient or if a patient refuses to receive the communication.

Med 18.05 Recordkeeping. A physician shall indicate on a patient's medical record he or she has communicated to the patient alternate viable modes of treatment. ■

Wisconsin Division of Health
OH 4151 (Rev. 8/87)
s.143.04 (6/84)

ACUTE AND COMMUNICABLE DISEASES CASE REPORT

Instructions on reverse side

DEMOGRAPHIC DATA PATIENT INFORMATION

A. CASE IDENTIFICATION *(All category I & II diseases)*

Last Name | First Name | M.I. | Date of Birth or Age (Mo. Day Yr.) | ☐ Married ☐ Single | Gender: ☐ M ☐ F

Address *(Street or RFD)* | Telephone No. ( )

City | State | Zip | County of Residence | Patient Died of This Illness? ☐ Yes ☐ No

School/Day Care/Workplace and Occupation | Parent or Guardian if a minor: *(Not necessary for STD)*

MORBIDITY DATA

B. DISEASE: | Date of onset of symptoms (Mo. Day Yr.)

Race: ☐ White ☐ Black ☐ Am. Indian ☐ Asian or Pacific Islander ☐ Other *(specify)* _____

Ethnic Origin: Hispanic ☐ Not Hispanic ☐

Please include confirmatory laboratory data, immunization dates.
Dates | Type of Test | Result

COMMENTS:

PLEASE COMPLETE the following section for the diseases specified.

SEXUALLY TRANSMITTED DISEASES

C. SYPHILIS

- ☐ Primary (Chancre present)
- ☐ Secondary (skin lesions, rash, etc.)
- ☐ Early Latent (asymptomatic, less than 1 year)
- ☐ Late Latent (over 1 year duration)
  - LATE ☐ Neurosyphilis
  - LATE ☐ Cardiovascular
  - LATE ☐ Other
- ☐ Congenital

☐ GONORRHEA ☐ CHLAMYDIA
(Check above boxes as appropriate)

- ☐ Asymptomatic
- ☐ Uncomplicated Urogenital (Urethritis, Cervicitis)
- ☐ Salpingitis (PID)
- ☐ Ophthalmia/Conjunctivitis
- ☐ Other (Arthritis, Cutaneous Lesions, etc.)
- ☐ Resistant Gonorrhea
  - ☐ Penicillinase - Producing
  - ☐ Tetracycline - Resistant
  - ☐ Other _____

OTHER STD

- ☐ Chancroid
- ☐ Primary genital herpes infection
- ☐ Granuloma inguinale
- ☐ Lymphogranuloma venereum
- ☐ Other STD cervicitis
- ☐ Other STD urethritis
- ☐ Other STD salpingitis (PID)

TREATMENT

Has patient been treated? Yes ☐ No ☐

Date(s) of treatment _____ (Mo. Day Yr.)

Type and amount of treatment _____

COMMENTS:

ENTERIC DISEASES

D. Salmonella, Shigella, Giardiasis, Campylobacter, Yersinia, Hepatitis A and Amebiasis

Check below if the Patient: YES	NO	UNK.	Check below if a member of the patient's household YES	NO	UNK.
☐	☐	☐	☐	☐	☐ Is a food handler
☐	☐	☐	☐	☐	☐ Attends or works at a day care center
☐	☐	☐	☐	☐	☐ Is a health care worker
☐	☐	☐	☐	☐	☐ Drinks unpasteurized milk

COMMENTS:

TUBERCULOSIS

E. Bacteriology (type of specimen)

Type of Test: Positive Negative Pending

Smear _____ Date ☐ ☐ ☐

Culture _____ Date ☐ ☐ ☐

☐ Not stated or unknown

If culture positive: ☐ Not done
- ☐ M. Tuberculosis
- ☐ Atypical Mycobacteria *(specify)* _____

X-ray

- ☐ Normal _____ Date
- ☐ Abnormal _____ Date

(Check one): ☐ Stable ☐ Worsening ☐ Improving
(Check one): ☐ Cavitary ☐ Noncavitary

- ☐ Not Done
- ☐ Unknown

Previous Diagnosis ☐ Yes ☐ No ☐ Unknown

Tuberculin Test:

Date: _____ (Mo. Day Yr.)

Positive (in mm induration) _____ mm

Negative ☐

Type of Test: (check box)

Mantoux (5TU-PPD) ☐

Multiple Puncture Device (screening only) ☐

☐ Not Done

Treatment:

- ☐ Isoniazid
- ☐ Ethambutol
- ☐ Rifampin
- ☐ Other *(specify)* _____

Date Treatment Started _____ (Mo. Day Yr.)

This patient's country of origin _____

Mo. ____ Yr. ____ arrived U.S.

WEEKLY REPORTABLE DISEASE

F. Chickenpox Cases - *(Category III)*

For Week Ending (Saturday Through Friday) _____ (Mo. Day Yr.)

Number ☐

COPIES A AND B - Mail to the local health officer. Copy A will be sent to the State Epidemiologist by the local health officer.

COPY C May be retained for patient's record.

PLEASE COMPLETE the following section for all reports

REPORTING SOURCE

G. Person or Agency Reporting:
Name:
Address:
Phone:

Attending Physician:
Name:
Address:
Phone:

Date of Report _____ (Mo. Day Yr.)

Date received by the local public health agency: _____ (Mo. Day Yr.)

COPY A—STATE EPIDEMIOLOGIST

TELEPHONE For Disease Consultation or For General Information (608) 267-9003	Instructions for Completing Attached **ACUTE AND COMMUNICABLE DISEASES CASE REPORT** DOH-4151 (Rev. 5/85)	Issued by Acute & Communicable Disease Epidemiology Section Bureau of Community Health and Prevention Wis. State Division of Health Box 309 Madison, WI 53701-0309

GENERAL INSTRUCTIONS

Diseases listed under each of the following categories are to be reported to the *local health officer located in the local public health agency of the patient's place of residence.* Use the attached 3-part carbon interleaved form for this purpose. Complete Section A, *Demographic and Morbidity Data,* for diseases in categories I and II. For diseases followed by two asterisks (**), give vaccination history. Follow-up epidemiologic information may be requested by local or state public health officials. Report the number of *Chickenpox* cases (Category III) weekly by aggregates on the same form as a category I or II disease. Complete Section G, person reporting, for *ALL* categories. Send copy "A" and copy "B" to the local health officer. Copy "C" may be retained with the patient's record.

REPORT THE FOLLOWING DISEASES TO _____ AT _____
Local Public Health Agency

_____
Address/Telephone No.

CATEGORY I

The following diseases are of urgent public health importance. Report *IMMEDIATELY* by telephone to your patient's local health officer upon identification of a case or suspected case. Complete and mail an Acute and Communicable Diseases Case Report (DOH-4151) within 24 hours.

- Anthrax
- Botulism
- Botulism, infant
- Cholera
- Diphtheria**
- Food or water-borne outbreaks
- Hepatitis, viral Type A
- Measles**
- Pertussis**
- Plague
- Poliomyelitis**
- Rabies (human)
- Rubella**
- Rubella (congenital syndrome)**
- Tuberculosis
- Yellow fever

CATEGORY II

The following diseases must be reported to the local health officer on an Acute and Communicable Diseases Case Report or by telephone within 72 hours of the identification of a case or suspected case.

- Acquired Immune Deficiency Syndrome (AIDS)
- Amebiasis
- Blastomycosis
- Brucellosis
- Campylobacter enteritis
- Encephalitis, viral *(specify etiology)*
- Giardiasis
- Hepatitis, viral Types B, non-A non-B (Type A is in Category I)
- Histoplasmosis
- Kawasaki syndrome
- Legionnaires' disease
- Leprosy
- Leptospirosis
- Lyme disease
- Malaria
- Meningitis, aseptic *(specify etiology)*
- Meningitis, bacterial *(specify etiology)*
- Meningococcal disease
- Mumps**
- Nontuberculous mycobacterial disease *(specify etiology)*
- Psittacosis
- Q fever
- Reye Syndrome
- Rheumatic fever (newly diagnosed)
- Rocky mountain spotted fever
- Salmonellosis
- Sexually transmitted diseases:
  - Chancroid
  - Chlamydia trachomatis
  - Genital herpes infection - Primary (First clinical episode only)
  - Gonorrhea
  - Granuloma inguinale
  - Lymphogranuloma venereum
  - Nongonococcal cervicitis
  - Nongonococcal urethritis
  - Sexually transmitted pelvic inflammatory disease
  - Syphilis
- Shigellosis
- Tetanus**
- Toxic-shock syndrome
- Toxic substance related diseases:
  - Infant methemoglobinemia
  - Lead intoxication *(specify Pb levels)*
  - Other metal poisonings
  - Other organic chemical poisonings
  - Pesticide poisoning
- Toxoplasmosis
- Trichinosis
- Tularemia
- Typhoid fever
- Typhus fever
- Yersiniosis

Also: Suspected outbreaks of other acute or occupationally-related diseases should be reported.

CATEGORY III

Report the total number of Chickenpox cases each week Saturday through Friday.

WISCONSIN STATUTE CHAPTER 143 AND ADMINISTRATIVE RULE CHAPTER HSS 145 REQUIRE REPORTING OF COMMUNICABLE DISEASES

Persons reporting include any person licensed under Ch. 441 and 448, Stats., or any other person having knowledge that a person has a communicable disease such as;

a. a person in charge of infection control at a health care institution.
b. school nurses, principals of schools and day care center directors.
c. laboratory directors.

For further information see Wisconsin Administrative Rule HSS 145

Must a Wisconsin physician report . . .

1. **Deaths?**
   Wisconsin statutes require that the following deaths must be reported *immediately* to the sheriff, police chief, or coroner of the county in which such death occurred:
   a. All deaths in which there are unexplained, unusual, or suspicious circumstances.
   b. All homicides.
   c. All suicides.
   d. All deaths following an abortion.
   e. All deaths due to poisoning, whether homicidal, suicidal or accidental.
   f. All deaths following accidents, whether the injury is or is not the primary cause of death.
   g. When there was no physician in attendance within 30 days preceding death.
   h. When a physician refuses to sign the death certificate.
   i. When, after reasonable efforts, a physician cannot be obtained to sign the medical certification as required under s. 69.18 (2) or (c) within 6 days after the pronouncement of death or sooner under circumstances which the coroner or medical examiner determines to be an emergency.

   Violations of the above are punishable by fine or imprisonment.

2. **Treatment of automobile accident injuries?**
   No, unless there is a death.

3. **Drowning?**
   Yes.

4. **Lead poisoning?**
   Yes, within 48 hours to the DHSS or local health officer.

5. **Suicide attempts?**
   No; only death by suicide is reportable.

6. **Sending of corpses to undertaker?**
   Yes. *Before* a physician sends a corpse to a funeral director, undertaker, mortician, or embalmer, he *must* notify the next of kin or a person who may be chargeable with the funeral expenses. There is a penalty for violation of this requirement.

7. **Live births?**
   Yes, but since November 1, 1986, physicians no longer have the primary statutory responsibility for filing birth certificates. Under 1985 Wisconsin Act 315, this responsibility is transferred to hospital administration. However, physician responsibility for the birth certificate is maintained for those births the physician attends outside the hospital. Filing the certificate with the county register of deeds must occur within five days after the birth. Results of required metabolic disorder tests need not be reported by physicians but positive test results must be reported by the State Laboratory of Hygeine.

8. **Communicable diseases?**
   Yes, to local health officers.

9. **Sexually transmitted diseases?**
   Yes, to local health officers; however, while diagnosed AIDS cases are reportable to local health officers as communicable diseases, a positive HIV test in the absence of a diagnosis of AIDS must be reported to the Division of Health but not to the local health officer. Reporting of a positive HIV test result to parties other than the DOH and others specifically authorized by statute is prohibited unless the patient consents.

10. **Tuberculosis?**
    Yes, to local health officers.

11. **Chronic alcoholics?**
    No, even if you know or believe it probable that they are driving automobiles.

12. **Drug addiction?**
    No.

13. **Abused or neglected children?**
    Yes. The law requires reports of "abused" (including sexual exploitation and "emotional damage") or "neglected" (those not receiving food, clothing, shelter or care, including medical care so as to "seriously endanger" the child's health) children, children threatened with injury, or those with exceptional educational needs. Wilful failure to report may subject a physician to a penalty; good faith reports provide immunity.

14. **Cancer?**
    No, but since Jan 1, 1987, physicians who diagnose or treat cancer patients who are *not hospitalized* for cancer are being asked to report those cases to the State Division of Health. *Hospitals are required* to report patient, diagnostic, and treatment information for every cancer case following the first admission.

15. **Abused elderly persons?**
    No, but any person with reasonable facts indicating physical or financial abuse, neglect or self-neglect of a person age 60 or older or who is subject to the infirmities of aging may report this to the agency designated by the county board to receive such reports.

The foregoing list incorporates questions most commonly asked, and is by no means a complete list of all that the statutes or department rules of the state require by way of reports from physicians.

The law prohibits a physician from disclosing, *except* as specifically required or authorized by law, any information which he or she acquired in attending a patient and which is necessary for him or her to treat that patient. Information provided to the Department of Health and Social Services which relates to personal facts about a patient may be used only for statistical or summary purposes or anonymously except as its disclosure may be necessary to provide services for the patient. Address: DHSS, 1 W Wilson St, PO Box 309, Madison, WI 53701. ■

Communicable disease reporting laws

THE WISCONSIN communicable disease rule, referred to as Chapter HSS 145, is particularly important to medical and public health professionals because it contains disease reporting responsibilities and a list of reportable diseases, adopts standards for disease prevention and control, and updates other disease control activities.

HSS 145 is organized into three subchapters: Subchapter I, General Provisions; Subchapter II, Tuberculosis; and Subchapter III, Sexually Transmitted Diseases. HSS 145 requires specific disease prevention and control measures, as contained in *Control of Communicable Diseases in Man,* 14th edition (1985), published by the American Public Health Association. This manual is a familiar resource to most public health professionals and infectious disease specialists in the State and is updated every five years in light of new knowledge of disease mechanisms and the effectiveness of specific control measures. Physicians should use the control measures contained in this manual in the instruction of their patients. The State Epidemiologist may also specify other disease control recommendations necessary for the control of a specific disease or condition.

The reporting of communicable diseases is required of physicians, nurses, laboratories, health care facilities, teachers in schools and day care centers, and any other persons knowing of the presence or suspected presence of a communicable disease. The list of communicable diseases which are to be reported reflects changing disease trends and the emergence of new diseases such as Acquired Immune Deficiency Syndrome, Legionnaires' disease, toxic-shock syndrome, and Lyme disease (see complete list at end of this article).

When a diagnosis of any of the diseases listed is suspected or confirmed, this fact must be reported (either verbally or by completing the Acute and Communicable Diseases Case Report form, DOH 4151, reproduced on page 60) to the local health officer in the public health agency serving the patient's place of residence. The local health officer is required to forward all reports of communicable diseases to the State Epidemiologist at the Wisconsin Division of Health and is also responsible for coordinating the local epidemiologic followup of reported diseases.

(A *Directory of City and County Public Health Agencies in Wisconsin* for reporting communicable diseases is available from the Acute and Communicable Disease Epidemiology Section, Bureau of Community Health and Prevention, Division of Health, Department of Health and Social Services, PO Box 309, Madison, Wisconsin 53701; or phone: 608/267-9003.)

The tuberculosis control measures have been revised to reflect current knowledge about treatment and transmission of the disease. The list of sexually transmitted diseases covered by HSS 145 has been expanded to include genital herpes infection (first clinical episode only), nongonococcal urethritis, chlamydia trachomatis, nongonococcal cervicitis, and sexually transmitted pelvic inflammatory disease, in addition to syphilis, gonorrhea, chancroid, granuloma inguinale, and lymphogranuloma venereum. In addition, the "Sexually Transmitted Disease Treatment Guidelines 1982," published by the US Department of Health and Human Services, is adopted by reference in this rule.

Copies of Chapter HSS 145 are available from the Bureau of Community Health and Prevention, Wisconsin Division of Health, PO Box 309, Madison, Wisconsin 53701; or phone: 608/267-9003. Questions regarding specific provisions of this rule may also be addressed to the above agency.

Editor's note: AIDS and HIV positive antibody tests must also be reported but under different sections of the statutes. AIDS is reportable, as a Category II communicable disease, to the local health officer and the State Division of Health. Positive HIV antibody test results do *not,* by themselves, constitute diagnosis of AIDS and under the law as of June 1987, positive test results must be reported to the State Epidemiologist but may *not* be reported to the local health officer. For specific information on AIDS and HIV antibody reporting requirements see article, "AIDS and HIV antibody testing and reporting," which appears in this issue on page 61.

— — —

Communicable diseases—Category I

The following diseases are of urgent public health importance and shall be reported by telephone to the local health officer in the public health agency serving the patient's place of residence immediately upon identification of a case or suspected case.

- Anthrax
- Botulism
- Botulism, infant
- Cholera
- Diphtheria
- Food- or water-borne outbreaks
- Hepatitis, viral Type A
- Measles
- Pertussis (whooping cough)
- Plague
- Poliomyelitis
- Rabies (human)
- Rubella
- Rubella (congenital syndrome)
- Tuberculosis
- Yellow fever

continued next page

This article was prepared originally by Susan J Stolz, MA and Jeffrey P Davis, MD of Madison and initially published in the June 1984 BLUE BOOK issue of the *Wisconsin Medical Journal.* It has been reprinted in subsequent issues with updating. Ms Stolz was formerly with the Section of Acute and Communicable Disease Epidemiology (Communicable Disease Laws); and Doctor Davis is State Epidemiologist and Chief, Section of Acute and Communicable Disease Epidemiology.

continued from preceding page

Communicable diseases—Category II

The following diseases are of less urgent public health importance and shall be reported to the local health officer in the public health agency of the person's place of residence by individual case report from or by telephone within 72 hours of the identification of a case or suspected case.

- Acquired Immune Deficiency Syndrome (AIDS)
- Amebiasis
- Blastomycosis
- Brucellosis
- Campylobacter enteritis
- Encephalitis, viral (specify etiology)
- Giardiasis
- Hepatitis, viral Types B, non-A non-B, or unspecified
- Histoplasmosis
- Kawasaki disease
- Legionnaires' disease
- Leprosy
- Leptospirosis
- Lyme disease
- Malaria
- Meningitis, aseptic (specify etiology)
- Meningitis, bacterial (specify etiology)
- Meningococcal disease
- Mumps
- Nontuberculous mycobacterial disease (specify etiology)
- Psittacosis
- Q fever
- Reye's syndrome
- Rheumatic fever (newly diagnosed)
- Rocky mountain spotted fever
- Salmonellosis
- Sexually transmitted diseases
  - Chancroid
  - Chlamydia trachomatis
  - Genital herpes infection (first clinical episode only)
  - Gonorrhea
  - Granuloma inguinale
  - Lymphogranuloma venereum
  - Nongonococcal cervicitis
  - Nongonococcal urethritis
  - Sexually transmitted pelvic inflammatory disease
  - Syphilis
- Shigellosis
- Tetanus
- Toxic-shock syndrome
- Toxic substance related disease
  - Infant methemoglobinemia
  - Lead intoxication (specify Pb levels)
  - Other metal poisonings
  - Other organic chemical poisonings
  - Pesticide poisoning
- Toxoplasmosis
- Trichinosis
- Tularemia
- Typhoid fever
- Typhus fever
- Yersiniosis

Suspected outbreaks of other acute or occupationally-related diseases

Communicable diseases—Category III

The total number of cases or suspected cases of the following communicable disease shall be reported on a weekly basis to the local health officer.

Chickenpox

— — —

Unlike the previous rules which detailed control methods for each disease, this rule adopts by reference the applicable methods of control contained in *Control of Communicable Diseases in Man,* 14th edition (1985), edited by Abram S Benenson, Published by the American Public Health Association. ■

WISCONSIN POISON CONTROL PROGRAM NETWORK

It is a health service that provides standardized poison management information and treatment to both medical professionals and the general public through a network of regional and satellite centers.

Each center is staffed by specially trained poison information professionals available to answer telephone inquiries 24 hours a day, seven days a week. Telecopying equipment enables the staff to make immediate contact with national headquarters in Pittsburgh when additional information or research is needed on difficult cases of ingestion.

The centers:

- recommend treatment procedures to physicians and to the public in poison emergencies.
- maintain a record of calls received, treatment advised or given and disposition of the case.
- report certain poison incidents to the Division of Health.
- conduct education and prevention activities in the community.

The two regional centers are:

Milwaukee Poison Center
Milwaukee Children's Hospital
1700 W Wisconsin Avenue
Milwaukee, WI 53233
Tel 414/931-4114

Poison Center—Madison Area
University Hospitals
600 Highland Avenue
Madison, WI 53792
Tel 608/262-3702

The satellite center is:

Green Bay Poison Center
St Vincent Hospital
835 So Van Buren St
Green Bay, WI 54305
Tel 414/433-8100

In addition, other small poison control centers in many other hospitals may have direct contact with a regional or satellite center to receive assistance as a "member center" of the network.

This information provided by the

WISCONSIN DEPARTMENT OF HEALTH AND SOCIAL SERVICES DIVISION OF HEALTH

PO Box 309 **Madison, Wis 53701**

Medical liability—A physician's rights and responsibilities

THIS ARTICLE is intended to provide information about medical liability insurance and outline the rights and responsibilities of physicians and medical liability insurance carriers in the resolution of medical liability disputes.

COVERAGE AND POLICIES

Coverage

Medical liability insurance covers injuries arising out of the rendering or failure to render professional services. In addition to treatment rendered by the insured physician, liability insurance policies may include coverage of such things as: the acts of employees (performed within the scope of such employment) and service by the insured as a member of a formal accreditation, standards review, peer review, or similar professional board or committee of a hospital or professional society.

SMS RECOMMENDS: Check your policy for a complete description of coverage including what type of coverage you have if you assume liability by signing any type of medical care delivery contract which has a "hold harmless clause." Contact your insurance agent, carrier or SMS with any questions.

Types of policies

Two basic types of policies are available in Wisconsin—occurrence and claims-made.

Occurrence policies cover all claims resulting from professional services rendered during the term of the policy regardless of when the suit is initiated.

Claims-made policies cover claims only if: 1) the policy was in effect at the time the services were rendered, and 2) the policy was in effect at the time the suit was initiated.

SMS ENDORSES PIC-Wisconsin which provides claims-made coverage and SMS SUPPORTS the continuous operation of WHCLIP, a state-run occurrence program to meet the diverse needs of SMS membership.

Limits and amounts of coverage

Wisconsin law requires all physicians, except government employees, to carry liability insurance coverage, or post a surety bond, of $400,000 per occurrence and $1 million per year as of July 1, 1988. The Patients Compensation Fund pays any portion of an award in excess of these limits.

SMS RECOMMENDS: That all physicians comply with the law's requirements for primary insurance coverage, and that all physicians review their policies to verify July 1, 1988, coverage requirements.

RIGHTS AND RESPONSIBILITIES

Provided the insured physician complies with the terms of the policy, the insurer is obligated to defend and pay damages on behalf of the insured in the event of a claim.

One of the most important responsibilities of the physician is to notify the insurance carrier on a timely basis of any claim made against the insured (or of any incident likely to result in a claim). Some policies set a given number of days within which the physician must notify the carrier, while others use such terms as: "as soon as practicable," "as soon as possible," "within a reasonable time," etc.

In the event of a claim or incident, the following information should be provided: name of insured, date and place of incident, circumstances of injury, name and address of injured party and any witnesses. The carrier will then notify you of any additional information which may be needed.

Physicians have both a right and responsibility to assist in the defense of a claim. The degree of participation granted to or required of the physician will vary from case to case and from one insurer to another. Likewise the desire to participate will vary among physicians.

1986 revisions to the state's medical malpractice laws replaced the Patients Compensation Panel system with a mandatory, non-binding mediation system. Anyone filing a malpractice claim after September 1, 1986 must first participate in a mediation process; and the physician against whom the claim is filed must attend or be represented by counsel. The new law prohibits formal discovery

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Reprints are available upon request to the SMS Division of Medical Policy and Practice, PO Box 1109, Madison, WI 53701; or phone 1-800-362-9080 or 608-257-6781.

from taking place until after mediation and bars either party from bringing expert witnesses or expert testimony into the mediation process. The mediators, however, may consult with experts.

SMS RECOMMENDS: That physicians become intimately involved in the development of the defense.

WHAT A PHYSICIAN CAN EXPECT

Outlined below is what SMS believes a physician can reasonably expect in his/her relationship with the carrier.

Competent defense counsel

The Wisconsin Health Care Liability Insurance Plan (WHCLIP) will, in most instances, honor physician requests that a particular defense attorney be appointed. While commercial carriers do not afford this opportunity, the physician can and should request a replacement if dissatisfied with the defense being provided.

Inasmuch as effective communication between the physician and attorney is essential to a successful defense, we see merit in providing the physician input into the selection of defense counsel. We also, however, recognize the expertise of carriers in this respect.

Regardless of how the defense attorney is selected it is critical that the physician and attorney work together to formulate a strong defense.

Although retained by the insurance carrier, the defense attorney owes his/her first allegiance to the insured physician. The physician is the client.

Participation in formulating the defense

The physician is entitled to:

- An initial conference to discuss the allegations and adjudication process;
- Participate in the mediation process, with or without counsel;
- An explanation of the discovery process (through which the opposing party's case is explored) and a tentative timetable for completion of discovery and development of the defense;
- Review all depositions, learned treatises, etc. obtained by counsel;
- Participate in the selection of expert witnesses and exhibits;
- Copies of all correspondence between defense counsel and other interested parties (carrier, claimant, witnesses, etc); and
- Full disclosure of the progress of all settlement negotiations.

We believe that most carriers and defense attorneys will welcome this type of participation. If, however, you feel you are not being allowed adequate input, discuss this with your assigned defense attorney. If your concerns are not allayed, contact your carrier. If still dissatisfied, contact SMS and we will attempt to resolve the problem.

OTHER CONSIDERATIONS

Under Wisconsin law, physicians DO NOT have the right to "veto" settlements agreed upon by the carrier and claimant. Therefore, it is extremely important that you keep abreast of the development of your defense. A strong defense will lessen the carriers' inclination to settle, while a lax defense may indeed prompt a settlement (regardless of your guilt or innocence).

Even though you have no legal right to veto actions of the carrier, there is an ethical obligation upon the carrier and its attorney to provide you with an explanation of the carrier's decisions regarding settlements and appeals. You should request that your defense attorney advise you on these matters prior to their being finalized. Generally, the carrier will base such decisions on advice from defense counsel.

You are also entitled to prompt information about new developments in your case, final settlements or awards, appeals, and other aspects of the defense of your case. This again illustrates the importance of your continuing communication with the defense attorney and his or her regular communications with you. You can best affect defense and/or settlement decisions through your defense attorney.

SMS advises that you become familiar with the terms of your medical liability insurance policy, notify your carrier promptly in the event of a suit and assert your right to participate fully in your defense.

For more information contact the Division of Medical Policy and Practice of the State Medical Society of Wisconsin.■

Support group helps physicians experiencing litigation

The State Medical Society of Wisconsin's Committee on Medical Liability has developed a system intended to address concerns physicians may have about psychological pressures emanating from malpractice claims.

Due to the number and severity of medical malpractice claims, physician premiums for liability insurance coverage are continuing to increase. But in addition to these monetary costs, many physicians find it difficult to maintain their professional poise when confronted with a lawsuit alleging medical malpractice.

Physicians may react to the stress of being sued in a variety of ways including anger, tension, headache or depression. Many may handle these reactions by suppressing them, while continuing to fulfill their responsibilities to patients and colleagues.

The State Medical Society's Physician Support Group will provide:

- emotional support.
- helpful information.
- an opportunity for physicians and spouses experiencing the anxiety of a malpractice suit to share their feelings with sympathetic listeners.

Our panel of concerned physicians and spouses, all of whom have been through this experience, is available on an individual basis to provide confidential assistance to any Wisconsin physician or spouse who requests it.

Program guidelines

The program is not intended to deal with the merits (or lack thereof) of any specific case. The purpose is to provide emotional support and helpful information to assist physicians and their spouses during this stressful period in their lives.

Confidentiality is intended to be maintained at all times. Individuals requesting this service will be given a list of support group panelists and will make their own determination of whom to contact.

The premise of the program is individual contact with open and frank discussions. There is no group interaction.

The only requirement is that the support physician should not be of the same specialty as the physician being sued, due to the tendency to discuss specifics of the case.

Panelist qualifications

Physicians

A practicing physician who has been a respondent in a malpractice suit. He or she knows the legal process involved in this type of litigation.

Any physician who meets the first criterion and believes he or she is able to offer support and helpful information to a colleague involved in a medical malpractice action is encouraged to participate.

Each participating physician is provided basic information on the purpose and function of the Physician Support Group.

Spouses

Spouses of physicians who have been a respondent in a medical malpractice action are often able to offer support and helpful information to their counterparts.

Each participating spouse is provided basic information on the purpose and function of the Physician Support Group.

Panelist guidelines

The program shall remain individualized, with an emphasis on personal contact and communication between the physician or spouse requesting information or assistance

Letter to physician named in a medical mediation case. Items mentioned in this letter as "enclosed" are available upon your request to the Medical Liability Committee at SMS Headquarters.

Dear Doctor:

According to our records, you have been named in a medical mediation case. Feelings such as anger, frustration and depression are common for physicians involved in a malpractice action. I am writing this letter to inform you that there are other physicians and spouses who have been through similar experiences and are willing to discuss those feelings.

As part of the work of the Medical Liability Committee, we have looked at the effect of the medical malpractice action on the physician and his/her family. It was the recommendation of the Medical Liability Committee to the Board of Directors that the State Medical Society establish a support structure for physicians and their families involved in medical malpractice actions. Part of our proposal recommended the establishment of a group of physicians and spouses who could serve as "sympathetic listeners" for the physicians and their families involved in a liability action.

I invite you and your spouse or significant other to utilize the program. Enclosed is a list of physicians and spouses who have volunteered to serve. Please feel free to contact any physician or spouse on the list. He or she will assure you of maintaining confidentiality.

Also, enclosed is a brief description of the program. Remember, talking to an experienced, knowledgeable peer about your frustrations is important. If you have further questions about the program or would like additional information, please feel free to contact Kit Nimtz at SMS, 1-800-362-9080.

Sincerely,

William J. Listwan, MD
Chairman
Medical Liability Committee■

and the panel member.

Information regarding inquiries, discussions and meetings, including identities of participants in this program, shall remain confidential between all involved individuals.

Those making inquiries about the program will remain anonymous. Names of panel members will be provided for individual contact, if so desired.

A mutually convenient time and setting of meetings is left entirely up to the parties involved and can be limited, if desired, to telephone calls only.

Although issues to be discussed may be wide-ranging, including feelings, concerns, fears, etc., **specific merits of the case should not be discussed.** The panel member should steer the conversation away from this particular topic.

Appropriate issues to discuss

Feelings, emotions, fears elicited by the legal action, loss of confidence, difficulty in making decisions, withdrawal, hostility, effects on personal life.

Persons in whom one can normally confide such as a spouse, legal counsel, close personal friend with whom absolute confidences can be kept, colleagues in same group practice.

Inappropriate issues to discuss

Specific merits (or lack thereof) of the case, including clinical management and circumstances surrounding case. Panelists should advise program participants that the specific factual and legal issues of the case should only be discussed after consultation with their legal counsel.

People interested in participating in the Physicians' Support Group should contact the SMS Division of Medical Policy and Practice.■

The WIPRO review process

Many physicians in Wisconsin have experienced a Wisconsin Peer Review Organization (WIPRO) audit. To assist physicians in the event they are reviewed, the State Medical Society of Wisconsin developed *A Guide to Medicare Audits: The WIPRO Review Process*. This article is a brief summary of the *Guide* which may be ordered by contacting the Division of Medical Policy and Practice.

WIPRO reviews are primarily concerned with care provided to Medicare patients while hospitalized. WIPRO performs two types of utilization reviews: preadmission reviews, reviews performed prior to admitting the patient and retrospective reviews, reviews of the services provided performed after discharge of the patient.

WIPRO also performs quality or integrity reviews. These are conducted during a retrospective review. A generic quality screen is used to identify possible quality of care problems. If a case fails to pass a screen, it is sent to a WIPRO physician advisor, who relies on his or her own medical judgment of the case. These screens are mandated by HCFA.

WIPRO also has the ability to apply sanctions. Sanctions may be in the form of a monetary fine or exclusion from the Medicare program. Sanctions result from the violation of an obligation placed on physicians to assure that services provided are:

- economical and only done when and to the extent medically necessary,
- of a quality that meets professionally recognized standards of health care, and
- supported by the appropriate evidence of medical necessity and quality in the form and fashion that the reviewing PRO may reasonably require.

If you are audited or you disagree with a review decision, the following steps should be taken:

1. Contact the Division of Medical Policy and Practice at 1-800-257-9080 for assistance in understanding the process and your rights and responsibilities.
2. Review the material originally submitted to WIPRO. Submit any additional information that they request or that you believe may aid in the review.
3. Discuss the case with the WIPRO Physician Advisor. This physician's name is included in the initial letter of pending denial and he or she makes the initial decision on whether to deny payment or pursue a violation.
4. It may be helpful to get an impartial review by the SMS Commission on Mediation and Peer Review. In cases where the commission agrees with the physician, it will support and assist the physician in his or her interactions with WIPRO.

The *Guide* describes the WIPRO review process, the procedures used, and the situations that trigger review. This information is valuable to physicians in avoiding unnecessary involvement with WIPRO and help in dealing effectively in those instances where WIPRO involvement is unavoidable.

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DECLARATION OF GENEVA

Adopted by the General Assembly of the World Medical Association at Geneva, Switerland, September, 1948

AT THE TIME OF BEING ADMITTED AS MEMBER OF THE MEDICAL PROFESSION:

I SOLEMNLY PLEDGE myself to consecrate my life to the service of humanity.

I WILL GIVE to my teachers the respect and gratitude which is their due.

I WILL PRACTICE my profession with conscience and dignity.

THE HEALTH OF MY PATIENT will be my first consideration.

I WILL RESPECT the secrets which are confided in me.

I WILL MAINTAIN by all means in my power, the honor and the noble traditions of the medical profession.

MY COLLEAGUES will be my brothers.

I WILL NOT PERMIT considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient.

I WILL MAINTAIN the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.

I MAKE THESE PROMISES solemnly, freely, and upon my honor.

Questions about medical records laws

THE ANALYSIS of Wisconsin law regarding record retention and inspection which begins on page 37 provides a good starting point for understanding the law. However, in day-to-day applications of the records laws, situations arise where a basic understanding does not supply a ready answer. The following questions and answers are based in part on some of the inquiries forwarded to the State Medical Society's legal department.

Who else besides patients are authorized to inspect and obtain copies of medical records?

The law provides that all patient healthcare records are confidential and may be released only to persons designated in §146.82, persons with the patient's informed consent or others authorized by the patient. Parents of minors are generally authorized as the legal guardian to inspect and receive copies of their children's medical records with two exceptions: when the child received treatment for venereal disease or drug abuse. If the child's parents are divorced, either parent may have access to the medical records ***unless the parent's rights have been terminated or limited by court order.*** Other exceptions to records confidentiality and access are discussed in adjacent columns.

What happens when Worker's Compensation claims are involved or when insurance companies and attorneys not representing the patient ask for records?

The records release statute does not specify two other situations in which patient records may be released without the patient's authorization. Under Wisconsin Statute §102.13(2), a patient who reports an injury alleged to be work-related or files an application for a Worker's Compensation hearing waives any physician-patient confidentiality with respect to any condition or complaint reasonably related to the condition for which the patient claims compensation. In addition, §102.13(1)(c)3. states that any physician attending a Worker's Compensation claimant for any condition or complaint reasonably related to the condition for which the claimant claims compensation *may* furnish to the employe, employer, Worker's Compensation insurer, or the Department of Labor and Human Relations information and reports relative to a compensation claim. This section holds harmless any physician who reports on an injury or disability to a Worker's Compensation insurance carrier or employer without a release from the patient.

Another situation where the patient waives the physician-patient confidentiality usually protecting his or her medical records occurs when the patient files claim in a court of law where his or her medical condition is relevant to the claim or uses his or her medical condition as a defense in a civil or criminal case. In the same manner, medical information concerning facts or immediate circumstances surrounding a homicide at trial or a proceeding to determine a child's paternity, or test results for intoxication or blood alcohol concentrations are exempt under the patient record confidentiality protection otherwise afforded by law. In this instance and, in fact, in any situation where someone other than the patient is claiming access to medical records, the records custodian should require proof to the claim of legal authorization.

In addition, there are situations where state law *requires* physicians and other healthcare providers to disclose information without proper authorization otherwise needed. If after examining a child, a physician has reason to suspect child abuse or that the injury was not incurred by accident, the physician must breach the physician-patient confidentiality and report the incident to local authorities named in other statutory provisions.

Does a patient have a right to his or her medical records if the physician providing the medical services does so under contract with or at the direction of an insurance company, attorney, or court order because the patient's medical condition is at issue?

If a patient has been directed to submit to an examination by a court order or under the direction of an insurance company for the purposes of a Worker's Compensation claim or other injury claim, he or she does not have the right to control record disclosure (physician-patient confidentiality has been waived). This idea is discussed in the previous questions with regard to who has access to medical information. However, does the patient have a right to copies and access to this medical information about him or herself although he or she has not paid for the services? The most reasonable answer is that the patient should still have access to this information regardless of who paid for the services because of the records law policy that patients, with some exceptions, should be able to find out about their health and medical treatment.

What are some of the exceptions to the records inspection law with respect to access?

In a few instances, federal law preempts state law concerning access to medical records. One such federal exemption concerns The Privacy Act which limits access by federal agencies to certain information about individuals, including certain health information. Another exception to statutory access granted to individuals and agencies under Chapter 146 is found in Chapter 51, the Mental Health Act. This set of laws grants greater protection to records

concerning treatment for mental illness, developmental disabilities, drug dependence and alcoholism than to general health records.

In addition to the limitations on access, there is a good argument that those not competent because of mental disease or defect are not entitled to the same right to inspect their health records generally granted under Chapter 146. In Chapter 51, several specific instances are stated where patients do have a right to their treatment records upon discharge from facilities where they underwent treatment for alcohol or drug addiction. However, no other guarantee to mental healthcare records is given by state law to those under the Mental Health Act's coverage—those receiving services for developmental disabilities or mental illness, and therefore, it is not clear whether those not legally competent because of their mental or emotional condition should or do have access.

Must I honor an insurance company's or attorney's request for copies of all the medical records regarding a patient?

All too often, a clinic or physician's office will receive a letter from an insurer or attorney accompanied by an authorization form signed by the patient requesting copies of all the medical records of the patient. For the most part, the patient is unaware that this request is made because they had previously signed a blank waiver form as a requirement for renewing or purchasing medical insurance. In many instances, the patient's records are voluminous and honoring this request would entail a substantial amount of staff time and office equipment use. If the authorization form does not state any limitation on records requested, the records custodian is required to supply all the information available, for a reasonable charge. However, after receiving this blanket request, the patient may revoke the authorization by signing another, more limited authorization for records release form. In this way, the records custodian can ask the patient, insurance company or attorney filing the waiver to restrict the request to those records relating to a specific medical condition or injury rather than the entire medical record.

Must I provide copies of a patient's records even if they have accounts in arrears?

There is no restriction to a patient's right to copy and inspect his or her records with regard to owing the physician or clinic money for the medical services provided. In other words, records cannot be held hostage for payment of outstanding bills. This prohibition appears in the *Current Opinions of the Judicial Council of the American Medical Association, 1986* and can be interpreted from the absence of any condition of this sort at state law. A physician or clinic can attempt to withhold records for reason of nonpayment but will be exposed to the risk of paying court costs should the patient get a court order for the medical records under Wis. Stat. §804.10(4).

I understand that there is another statutory provision that limits copying charges to 10 cents a copy and $2 per x-ray—does this law apply to me?

In another section of the Wisconsin Statutes, there is a provision that limits the charge a hospital can make for reproducing records when involved in a suit as a party, under court order for cause shown, or upon a properly authorized request of an attorney. This provision, §908.03(6m)(b), therefore applies only to hospitals under the situation described and does not affect the copying charges permitted by law under Chapter 146. The only term used to describe what a healthcare provider may charge for copying records and x-rays is "reasonable." ■

Insurance underwriting and HIV antibody testing

The Wisconsin Office of the Commissioner of Insurance has announced an administrative rule concerning access by insurance companies to HIV antibody test results. The rule became effective June 1, 1987.

The new rule, Wisconsin Administrative Code section Ins 3.53, allows life and health insurers to require applicants for ***individual*** life and health insurance policies to undergo HIV antibody testing as part of the application process. The rule also provides for insurers to require applicants for ***individual*** life and health insurance to reveal results of previous HIV antibody tests provided: (1) the test is one approved by the state epidemiologist (series of ELISAs followed by Western Blot) and (2) the test was ***not*** conducted through a counseling and testing site.

Wisconsin law ***prohibits*** insurers from:

(1) requiring HIV antibody tests when underwriting group policies;

(2) requiring applicants to reveal HIV antibody results obtained through counseling and testing sites;

(3) submitting HIV antibody test results to the Medical Information Bureau (a nonprofit association of life insurance companies formed to conduct a confidential exchange of underwriting information) unless informed, written consent was received from the applicant prior to administering the test; and

(4) requiring an applicant to undergo HIV antibody testing unless the cost of the testing is borne by the insurer.■

Retention and inspection of patients' records

IT IS GENERALLY agreed that ownership of medical and hospital records rests, respectively, with the physician and the hospital. Their beneficial ownership, that is the right to have them used for one's benefit, is in the patient although the right to possession remains in the physician or hospital. The doctor-patient-hospital relationship has been considered by the legislature and the courts. They have declared it to be in the public interest that the patient have access to relevant records concerning his medical care and treatment.

Because of the long-standing uncertainty regarding the rights of physicians, hospital personnel, patients and others in regard to health care records, efforts both statutory and private have been made to clarify this situation. In 1959 the State Medical Society of Wisconsin and the Wisconsin Hospital Association jointly developed an *Interpretation* seeking to define what is a health record and restate the respective rights of various interested parties in them. This *Interpretation* was printed in the June 1975 Blue Book issue of the *Wisconsin Medical Journal.* (74 *WMJ* 30)

The law under which the *Interpretation* was prepared has been subsequently amended. To the extent of that amendment, the *Interpretation* is no longer valid. It does provide a framework from which to view the issues involved, this framework having been developed jointly by the health professionals most directly involved. The new statute, Sec. 804.10(4), Wis. Stats., is discussed in the box accompanying this article. It deals with authorization by a patient for the examination or inspection of that patient's health care records.

More recently, Secs. 146.81-.83, Wis. Stats., were enacted effective 1980. This new law deals with the release of health care records by consent and without consent. Health care records are defined as "all records related to the health of a patient prepared by or under the supervision of a health care provider." Consent may be given by the patient or one legally permitted to act on the patient's behalf. Consent must contain the name of the patient, the purpose of disclosure of the records, the type of information to be disclosed, the person to whom disclosure may be made, which providers are to make the disclosure, and the time period during which the consent is effective. Access without consent of the patient is permitted for staff, accreditation or review committee use, performance of health care services or consultation regarding them, billing, collecting and payment of claims, on court order, on written request from an appropriate government agency, and for research purposes subject to particular conditions. The new law also covers the subject of patient access to health care records.

Since a patient does have a general right to inspect his medical and hospital records, the question how long to retain records is automatically raised.

A. Retention of Records

For purposes of this article patients can be classified into three legal categories. Each category calls for retention of records for different periods. These are patients (1) over 18 who are mentally competent; (2) over 18 who are mentally ill; and (3) under 18.

Among others, the following reasons for retention of patient records, whether in original or reproduced form, must be considered:

1. To aid medical science; also to facilitate the care of a particular patient who requires treatment or hospitalization at a later time.
2. To provide a record for the assistance of the patient in enforcing his claim for injuries against others than the physician, hospital, or members of their respective staffs.
3. To assist the physician, hospital, a member of the medical or nursing staff, or other personnel in defending against an allegation of negligence made by or on behalf of the patient.
4. To assist the physician or hospital in collecting an unpaid debt due from a patient.

Recommendations

The following recommendations apply to each of the foregoing reasons for retention of records above noted.

1. As to the length of time for retaining records as an aid to medical science or to the patient himself, this will depend in part upon the facilities of the physician's office or the size and character of the hospital and will necessarily involve the judgment of the particular physician or of the medical staff of the hospital. In any event this is a matter of medical judgment and not legal considerations.
2. A mentally normal patient of legal age has *3* years within which to sue *for personal injuries.* If a patient elects to sue on *a contract* rather than for alleged *negligence,* he has *6* years in which to do so. In rare instances which would almost never apply to a patient-physician relationship, he might have up to 20 years. Such

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unusual situations would ordinarily be known to the physician's attorney. To aid the patient in enforcing his claims against others, it is recommended that records be retained for at least 6 years. There is no *legal* requirement for accommodating a former patient longer than the suggested 6 years, although where fraud is alleged, the injured party has 6 years in which to sue *after* discovery of the fraud. For example, a surgeon is chargeable with "fraud" who is aware he has left a foreign object in a patient's body but does not disclose that fact to the patient, or the latter's representative.

3. The period recommended for retention of patient records to defend against an allegation of negligence would depend upon the category into which the patient falls. The principal categories can be summarized as follows:

893.55 Medical malpractice; limitation of actions; limitation of damages; itemization of damages. (1) Except as provided by subs. (2) and (3), an action to recover damages for injury arising from any treatment or operation performed by, or from any omission by, a person who is a health care provider, regardless of the theory on which the action is based, shall be commenced within the later of:

(a) Three years from the date of the injury, or

(b) One year from the date the injury was discovered or, in the exercise of reasonable diligence should have been discovered, except that an action may not be commenced under this paragraph more than 5 years from the date of the act or omission.

(2) If a health care provider conceals from a patient a prior act or omission of the provider which has resulted in injury to the patient, an action shall be commenced within one year from the date the patient discovers the concealment or, in the exercise of reasonable diligence, should have discovered the concealment or within the time limitation provided by sub. (1), whichever is later.

(3) When a foreign object which has no therapeutic or diagnostic purpose or effect has been left in a patient's body, an action shall be commenced within one year after the patient is aware or, in the exercise of reasonable care, should

893.56 Health care providers; minors actions. Any person under the age of 18, who is not under disability by reason of insanity, developmental disability or imprisonment, shall bring an action to recover damages for injuries to the person arising from any treatment or operation performed by, or for any omission by a health care provider within the time limitation under s. 893.55 or by the time that person reaches the age of 10 years, whichever is later. That action shall be brought by the parent, guardian or other person having custody of the minor within the time limit set forth in this section.

History: 1977 c. 390; 1979 c. 323.

   A. If the patient is over 18 and mentally competent, the Wisconsin Statutes require that he start an action for alleged negligence within 3 years after the alleged act.
   B. If the patient is over 18 and mentally ill at the time of his treatment or hospitalization, or becomes so within 3 years thereafter, suit must be brought on his behalf, or by him if he recovers, within one year of his recovery, and if he does not recover, within a maximum of 8 years after the alleged negligence.
   C. If the patient is a mentally normal minor at the time of treatment or hospitalization, suit for injuries resulting from alleged malpractice by a health care provider must be brought on behalf of the minor within the later of: (i) 3 years after the injury or (ii) one year from the date the injury was, or should have been, discovered within a maximum of five years after the alleged injury, or (iii) the time the minor reaches the age of 10.
   D. If the patient was a minor and mentally ill at the time of the alleged negligence, and becomes mentally normal by age 18, he must sue for the alleged negligence by the time he is 20, or within three years from the date of the injury, whichever is later. If such patient remains insane after reaching age 18, his guardian must start suit within two years of his recovery, or before the patient is 20, whichever occurs later, all within a maximum of eight years after the alleged negligence.

4. To the extent that patients' records are retained to assist in collection of accounts, such claim must be enforced by the physician or hospital within 6 years of the time it was incurred, unless such time was extended by act of the person owing the account.

An accurate and durable reproduction of the record on microfilm or similar process is as fully admissible before a court as the original itself. *Therefore, the originals of your records, once they are microfilmed, may be destroyed. However, it is advisable to keep the original record for at least 3 years or until the patient has paid your bill.* The reasons for this recommendation are:

1. The original is in many ways more convenient to handle and to read than microfilm;
2. The opportunity for physical examination of an original patient record minimizes the chance of suspicion or an assertion that something is missing.

B. Inspection and Copying of Medical Records:

As a general rule, the right to inspect or copy medical records is based on the consent for such action by the patient or one legally authorized to act for the patient. The issue may arise in any of several situations and in the absence of a statutory exception covering the particular situation the physician should permit inspection and copying of a patient's medical records only by the patient or by one who has a written authorization from the patient (or one legally allowed to act on behalf of the patient) stating the extent of the authorization and describing the records covered by the authorization.

SECTION 804.10(4)

The general rule regarding inspection and copying of medical records is codified in Section 804.10(4), Wisconsin Statutes. It is set out in the box below.

A physician or hospital administrator, and anyone designated by either of them is urged to read this article *before* allowing the inspection or copying of medical records and reports which are in his custody.

An authorization from or on behalf of a patient allowing the designated person to inspect and copy medical or hospital records or reports concerning the patient's care and treatment may not specify what specific records are covered. The physician on the other hand may have records that go back many years and cover more than one treatment or series of treatments, and more than one illness or hospitalization, or more than one member of a family.

Before complying with the request of a patient to inspect and copy his records, the physician should confer, if practical, with the patient or his representative to ascertain *what* illness, *what* treatment, and *what* period of time are intended by the authorization. If by any chance the records or reports contain material relating to conditions which would be embarrassing to the patient or which might involve other members of the immediate family, the patient or a representative might be very grateful to have the physician point this out and delete them from any preparation.

If practical, the physician might also ascertain who suggested the copying of records. It could be important whether this was another physician, an insurance company, an employer, or an attorney for any such parties.

Some physicians are requesting not only that the time periods to be copied from a medical record or report be specified, but also that each particular illness be specified in the authorization from the patient.

Once the decision has been made how far back to go and just what portions of the total medical record are to be copied, the physician or hospital should *not* let the record leave the premises. For the information of physicians, the statute does *not* authorize the removal of medical or hospital records from the premises. Further, the physician or hospital should *not* permit *anyone* outside the staff to copy the record except in the presence of a staff member.

Whether by intention or not, the physician or hospital might lose a portion of the record if they do not observe these precautions, and such loss could prove a serious handicap later.

Following are some major considerations and safeguards to be observed by a custodian of medical records and reports:

1. Validity of Authorization

Upon being presented with an authorization form for the inspection or copying of medical records and reports, physicians or hospitals must assure themselves that (1) the patient in fact signed the authorization, (2) was of legal age, and (3) had the *mental capacity* to know what he was signing. A minor or incompetent must act through his guardian. Where there is no formal guardianship of a minor, a parent may sign as the natural guardian except where the minor is emancipated as by marriage or self-support.

The physician or hospital must take such precautions as are necessary to satisfy themselves that those designated in the authorization are thereby empowered to inspect and copy the medical records or reports covered by the authorization.

The physician or hospital representatives must also be satisfied that the *person presenting* the authorization to inspect or copy records is the *identical person named* in such instrument. So long as there is any reasonable doubt as to the identity of a person presenting authorization to inspect or copy records, the physician (or his representative) or the hospital (or his representative), depending upon which place the authorization is presented, is warranted in refusing to honor such authorization. The same is true if there is any substantial question as to the auth-

STATUTE: 804.10(4)

"804.10(4). Upon receipt of written authorization and consent signed by a person who has been the subject of medical care or treatment, or in case of the death of such person, signed by the personal representative or by the beneficiary of an insurance policy on the person's life, the physician or other person having custody of any medical or hospital records or reports concerning such care or treatment, shall forthwith permit the person designated in such authorization to inspect and copy such records and reports. Any person having custody of such records and reports who unreasonably refuses to comply with such authorization shall be liable to the party seeking the records or reports for the reasonable and necessary costs of enforcing the party's right to discover."

enticity of the signature or the mental capacity or age of the patient.

The statute authorizes the personal representative, or the beneficiary of a life insurance policy, to sign an authorization in case of a patient's death. If you receive such an authorization you can ask the personal representative to provide you with a certified copy of his authority to act. This will take the form of "Domiciliary Letters" or other documentary evidence of appointment or authorization which are issued by the Circuit Court branch handling probate matters.

In the case of the beneficiary of life insurance, you can ask for a certified statement from the insurance company that (1) a policy on the patient was in force at the time of his death, and (2) the person signing the authorization is the beneficiary under the policy.

The burden of proof is on the person seeking the information and the physician has no duty to release such information until he is satisfied that the person asking is so authorized. On being satisfied that the authorization presented is properly signed, as previously outlined, that the person presenting it is the person named therein, and that no question of mental capacity or of minority is involved, it then becomes the duty of the physician or hospital to permit such person to inspect and copy "any medical or hospital records or reports concerning" the care or treatment designated in the authorization. Exactly *what* records and reports may be inspected and copied is discussed in point 2 immediately following.

2. What Can Be Inspected And Copied

It is first necessary to determine what must be made available for inspection and/or copying.

It is believed that under a fair interpretation of subsection (4) the physician's records and reports (office or hospital), and the hospital clinical record or chart should be made available for inspection or copying.

In the case of x-rays there seems to be some disagreement among legal authorities as to whether they are part of the medical record as such, or are technically photographs. It is advised that x-rays be inspected *only* under proper supervision, in the case of a physician's office by the physician in charge, an associate, or the designee of either, in the case of a hospital or other institution by a qualified physician, or in the event of his unavailability, by a person designated by the administrator.

X-rays must *not* be taken from the office of a physician or other custodian by a patient unless required by a court order or subpoena. When either of the latter is served on the custodian of medical records or reports, Section 804.10(4) *is no longer applicable,* and the authorization is no longer in force.

One of the results of the increasingly comprehensive services of the modern hospital, especially teaching institutions, is the development and maintenance of *two* types of records relating to a patient. One relates directly to his care and treatment, and is the direct professional responsibility of the attending physician and of those acting under him, and may be described as the "official records and reports." The other has sometimes been described as "educational records," which are typically made by nonmedical personnel as part of their training, or at least for purposes not directly related to the "medical care and treatment" of the particular patient.

It is believed that no record or report, other than that made or approved by the physician in charge, or by a consultant, or resident, or by a registered nurse who is recording her/his acts or observations made pursuant to special or standing orders, technically relates to the "medical care or treatment" of the patient, as that phrase is used in the new statute. Nothing but one of the above should be furnished for inspection or copy.

Any *other* writings should be kept *separately* but *not* as a part of the patient's official record, for the reason that the persons making such writings are not professionally responsible for the patient, are not licensed to practice medicine, and are not necessarily recording acts or observations made pursuant to orders of the attending physician. Such writings are not authentic "records" relating to the care of treatment of the patient.

3. Safeguards

The following safeguards are recommended:

(a) Section 804.10(4) does *not* in words or by implication, give a right *to remove* any records from a physician's office, or hospital, the records being the legal property of the physician or hospital.

As an act of prudence, the hospital or physician should require that inspection and copying be carried on *in the presence* of a custodian (hospital or physician), or the representative of either. This statute does *not* require a physician or hospital to copy any records at the request of a patient or his representative. (See below, "Patient Access" under Section 146.83.) If a request is made by a patient or his representative, and the request is granted, the physician or hospital making such copy is entitled to make a reasonable and realistic charge for doing so.

As a precautionary measure to hospital administrative personnel and to physicians, it is suggested that under no circumstances should copies of any medical or hospital records or reports, which are prepared by a representative of the patient, be signed, initialed or subscribed to in any manner that may indicate authenticity and accuracy of such copies.

(b) Few people, other than medically trained personnel, know what is important in a hospital or medical record. For that reason a hospital librarian or other authorized person, or a physician, may in

some situations be able to satisfy a request by making inquiry as to what the patient or his representative really wants from the records, and reading the material relative to the inquiry. This may save a great deal of examining, copying, and inconvenience to everyone concerned.

(c) The word "forthwith" used in connection with the right to inspect and copy records does *not* mean "immediately," but as soon as the convenience of a physician, an administrator, or a record librarian, *reasonably* permits, after taking into account the urgency of prior demands on their time and personnel and whether advance notice had been given of the demand of the particular patient.

(d) When there is any indication that legal proceedings may ensue, the physician or hospital served with a proper authorization to examine or copy a patient's records should promptly notify the insurance carrier of this fact, and also the attorney of the physician or hospital. It is recommended that, in the interest of the patient, the hospital, and the physician, the knowledge of any such authorization be given by the person receiving same to the other interested parties.

4. No Authorization Forms Suggested

Since no words appear in Section 804.10(4) prescribing the form of an authorization to inspect and copy a patient's medical or hospital records or reports concerning his care or treatment, model forms are not suggested. (See below the elements of "informed consent.") The observance of the precautions and safeguards emphasized earlier in this article should assure that the patient's interest is protected while at the same time protecting the professional or institutional provider of services.

SECTIONS 146.81-.83

The most important exceptions to the general rule of confidentiality have been collected in Sections 146.81-.83, Wis. Stats. This law, adopted in 1979, defines the essential terms relating to "patient health care records," codifies the right of patients to have access to their records, recognizes the general rule of confidentiality of records, and enumerates the major exceptions to the general rule. A copy of Sections 146.81-.83 appears in boxes on following pages.

1. Definitions

The statutory definitions of "health care provider," "Patient," and "patient health care records" are virtually all inclusive. Section 146.81, Wis. Stats. The law is intended to cover all health records of all patients of all providers.

In addition the law defines "informed consent." This is the statutory equivalent of the authorization referred to above. It means the *written* consent for disclosure of information from a patient's health care records and must include: the patient's name,

146.81 Definitions. In ss. 146.81 to 146.83:

(1) "Health care provider" means a nurse registered or licensed under ch. 441, a chiropractor licensed under ch. 446, a dentist licensed under ch. 447, a physician, podiatrist or physical therapist licensed under ch. 448, an optometrist licensed under ch. 449, a psychologist licensed under ch. 455, a partnership thereof, a corporation therof that provides health care services, an operational cooperative sickness care plan organized under ss. 185.981 to 185.985 that directly provides services through salaried employes in its own facility, or an inpatient health care facility as defined in s. 140.85(1).

(2) "Informed consent" means written consent to the disclosure of information from patient health care records to an individual, agency or organization containing the name of the patient whose record is being disclosed, the purpose of the disclosure, the type of information to be disclosed, the individual, agency or organization to v 'ich disclosure may be made, the types of health care providers making the disclosure, the signature of the patient or the person authorized by the patient, the date on which the consent is signed and the time period during which the consent is effective.

(3) "Patient" means a person who receives health care services from a health care provider.

(4) "Patient health care records" means all records related to the health of a patient prepared by or under the supervision of a health care provider, but not those records subject to s. 51.30.

(5) "Person authorized by the patient" means the parent, guardian or legal custodian of a minor patient, as defined in s. 48.02(9) and (11), the guardian of a patient adjudged incompetent, as defined in s. 880.01(3) and (4), the personal representative or spouse of a deceased patient or any person authorized in writing by the patient. If no spouse survives a deceased patient, "person authorized by the patient" also means an adult member of the deceased patient's immediate family, as defined in s. 632.78 (3) (d). A court may appoint a temporary guardian for a patient believed incompetent to consent to the release of records under this section as the person authorized by the patient to decide upon the release of records, if no guardian has been appointed for the patient.

146.815 Contents of certain patient health care records

(1) Patient health care records maintained for hospital inpatients shall include, if obtainable, the inpatient's occupation and the industry in which the inpatient is employed at the time of admission, plus the inpatient's usual occupation.

(2) (a) If a hospital inpatient's health problems may be related to the inpatient's occupation or past occupations, the inpatient's physician shall ensure

continued on next page

continued from preceding page

that the inpatient's health care record contains available information from the patient or family about these occupations and any potential health hazards related to these occupations.

(b) If a hospital inpatient's problems may be related to the occupation or past occupations of the inpatient's parents, the inpatient's physician shall ensure that the inpatient's health care record contains available information from the patient or family about these occupations and any potential health hazards related to these occupations.

(3) The department shall provide forms that may be used to record information specified under sub. (2) and shall provide guidelines for determining whether to prepare the occupational history required under sub. (2). Nothing in this section shall be construed to require a hospital or physician to collect information required in this section from or about a patient who chooses not to divulge such information.

146.82 Confidentiality of patient health care records.

(1) CONFIDENTIALITY. All patient health care records shall remain confidential. Patient health care records may be released only to the persons designated in this section or to other persons with the informed consent of the patient or of a person authorized by the patient.

(2) ACCESS WITHOUT INFORMED CONSENT. (a) Notwithstanding sub. (1), patient health care records shall be released upon request without informed consent in the following circumstances:

1. To health care facility staff committees, or accreditation or health care services review organizations for the purposes of conducting management audits, financial audits, program monitoring and evaluation, health care services reviews or accreditation.

2. To the extent that performance of their duties requires access to the records, to a health care provider or any person acting under the supervision of a health care provider or to a person licensed under s. 146.35 or 146.50, including but not limited to medical staff members, employes or persons serving in training programs or participating in volunteer programs and affiliated with the health care provider, if:

a. The person is rendering assistance to the patient;

b. The person is being consulted regarding the health of the patient; or

c. The life or health of the patient appears to be in danger and the information contained in the patient health care records may aid the person in rendering assistance.

3. To the extent that the records are needed for billing, collection or payment of claims.

4. Under a lawful order of a court of record.

5. In response to a written request by any federal or state governmental agency to perform a legally authorized function, including but not limited to management audits, financial audits, program monitoring and evaluation, facility licensure or certification or individual licensure or certification. The private pay patient may deny access granted under this subdivision by annually submitting to the health care provider a signed, written request on a form provided by the department. The provider, if a hospital or nursing home, shall submit a copy of the signed form to the patient's physician.

6. For purposes of research if the researcher is affiliated with the health care provider and provides written assurances to the custodian of the patient health care records that the information will be used only for the purposes for which it is provided to the researcher, the information will not be released to a person not connected with the study, and the final product of the research will not reveal information that may serve to identify the patient whose records are being released under this paragraph without the informed consent of the patient. The private pay patient may deny access granted under this subdivision by annually submitting to the health care provider a signed, written request on a form provided by the department.

7. To a county agency designated under s. 46.90 (2) or other investigating agency under s. 46.90 for purposes of s. 46.90 (4) (a) and (5). The health care provider may release information by initiating contact with the county agency without receiving a request for release of the information from the county agency.

8. To the department under s. 46.73. The release of a patient health care record under this subdivision shall be limited to the information prescribed by the department under s. 46.73 (2).

9. To staff members of the protection and advocacy agency designated under s. 51.62 (2) or to staff members of the private, nonprofit corporation with which the agency has contracted under s. 51.62 (3) (a) 3, if any, for the purpose of protecting and advocating the rights of a person with development disabilities, as defined under s. 51.62 (1) (a), who resides in or who is receiving services from an inpatient health care facility, as defined under s. 51.62 (1) (b), except that if the patient has a guardian information concerning the patient obtainable by staff members of the agency or nonprofit corporation with which the agency has contracted is limited to the name, birth date and county of residence of the patient, information regarding whether the patient was voluntarily admitted, involuntarily committed or protectively placed and the date and place of admission, placement or commitment, and the name and address of any guardian of the patient and the date and place of the guardian's appointment. Any staff member who wishes to obtain additional information shall notify the patient's guardian in writing of the request and of the guardian's right to

object. The staff member shall send the notice by mail to the guardian's address. If the guardian does not object in writing within 15 days after the notice is mailed, the staff member may obtain the additional information. If the guardian objects in writing within 15 days after the notice is mailed, the staff member may not obtain the additional information.

10. To persons as provided under s. 655.17 (7) (b), as created by 1985 Wisconsin Act 29, if the patient files a submission of controversy under s. 655.04 (1), 1983 stats., on or after July 20, 1985 and before June 14, 1986, for the purposes of s. 655.17 (7) (b), as created by 1985 Wisconsin Act 29.

11. To a county department, as defined under s. 48.02 (2g), a sheriff or police department or a district attorney for purposes of investigation of threatened or suspected child abuse or neglect or prosecution of alleged child abuse or neglect if the person conducting the investigation or prosecution identifies the subject of the record by name. The health care provider may release information by initiating contact with a county department, sheriff or police department or district attorney without receiving a request for release of the information. A person to whom a report or record is disclosed under this subdivision may not further disclose it, except to the persons, for the purposes and under the conditions specified in s. 48.981 (7).

(b) Unless authorized by a court of record, the recipient of any information under par. (a) shall keep the information confidential and may not disclose identifying information about the patient whose patient health care records are released.

146.83 Patient access to health care records.

(1) Except as provided in s. 51.30 or 146.82 (2), any patient or other person may, upon submitting a statement of informed consent:

(a) Inspect the health care records of a health care provider pertaining to that patient at any time during regular business hours, upon reasonable notice.

(b) Receive a copy of the patient's health care records upon payment of reasonable costs.

(c) Receive a copy of the health care provider's X-ray reports or have the X-rays referred to another health care provider of the patient's choice upon payment of reasonable costs.

(2) The health care provider shall provide each patient with a statement paraphrasing the provisions of this section either upon admission to an inpatient health care facility, as defined in s. 140.85 (1), or upon the first provision of services by the health care provider after April 30, 1980.

(3) The health care provider shall note the time and date of each request by a patient or person authorized by the patient to inspect the patient's health care records, the name of the inspecting person, the time and date of inspection and identify the records released for inspection.

the purpose for disclosure of the information, the type of information to be disclosed, to whom disclosure may be made, what providers must make the disclosure, the date of the consent, the period during which the disclosure consent is effective, and the signature of the patient or the "person authorized by the patient" (also a defined term).

As defined, "informed consent" is more specific and detailed than general authorization for inspection and copying records as discussed above. Because of the inclusive wording of the definitions it can be argued that all releases of information from health records are subject to this part of the law,

CONSENT TO RELEASE MEDICAL INFORMATION

I, _____ do hereby
(name of patient)

consent to and authorize _____,
(name of physician or health care institution)

to disclose to _____
(specific individual or organization)

information from my medical records relating to my identity, diagnosis, prognosis or treatment compiled during my medical treatment(s)/hospitalization from _____ (date) to _____ (date). I understand

that the specific type of information to be disclosed includes: _____

_____

I understand that this consent may be revoked except to the extent that action has already been taken in reliance thereon, and that this authorization for disclosure will be effective until:

_____
(time or condition)

_____
Signature of Patient . . . . . OR

_____
Person Authorized by the Patient* and

_____
his/her relationship to patient

_____
Witness

Dated this _____ day of _____, 19__ .

NOTE TO RECIPIENT OF INFORMATION. This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosure of this information without the specific written consent of the patient or legal representative involved.

*NOTE: Person authorized by the patient means the parent, guardian, or legal custodian of a minor patient or a patient adjudged incompetent; the spouse or personal representative of a deceased patient; or any person authorized in writing by the patient which is witnessed and dated.

notwithstanding the different phrasing of Section 804.10(4). For safety's sake it would be well to insist that any consent or authorization meet the standards of Section 146.81.

Other inconsistencies between the definitions in Sections 146.81 and 804.10(4) are relatively minor but may be significant in particular situations (e.g., disclosure of information from the records of a deceased patient).

2. Occupational Health

Physicians under Section 146.815 are to ensure that a hospitalized patient's records contain available information on the patient's occupation and health hazards related to it if the condition being treated may be occupation related. Information on the occupation of a patient's parents must also be included if relevant to the condition of the patient.

The responsibility under this section of the law is imposed on physicians but this information does not have to be obtained from any patient who refuses to disclose it.

3. Statutory Exceptions

The general rule of confidentiality of patient records is reiterated in Section 146.82. Following that statement the law lists six situations in which information from a patient's health care records may be released without informed consent. These include: management, financial, and service audits and accreditation; treatment or consultation regarding treatment of the patient; billing and collection of claims; under court order; government investigations; and research, where the product of this research will not identify individual patients. As to the last two (government investigation and research) private pay patients may deny access to their records by executing a form provided by the Department of Health and Human Services. (This form was not available for several months after the law became effective.) Anyone obtaining information under these exceptions may not, without court authority, disclose the information received.

Perhaps the most critical exception deals with governmental investigations. This includes the investigation of complaints by license law agencies. This exception exists if there is a written request by the agency and it is to assist it in performing a legally authorized function. The power to compel disclosure is conditioned upon the agency complying precisely with the law. If a physician receives such a request, care should be exercised to determine that it meets the requirements of the statute since this is an exception to the general rule of confidentiality.

Where the governmental investigation is being conducted to ascertain whether a physician has been guilty of unprofessional conduct, an administrative rule of the Medical Examining Board, Med 12.03(1), must be considered to determine whether the agency's powers are being lawfully exercised. This rule, which establishes the Examining Board's investigative procedures, permits such investigations to be conducted by an agent of the Examining Board acting under the supervision and direction of the secretary or another member of the Examining Board. There is some conflict in the law between the powers of the Examining Board and the Department of Regulation and Licensing in investigative matters but any investigation conducted under the authority of the Examining Board must meet its standards.

4. Patient Access

The law also addresses patient access to health records. Section 146.83, Wis. Stats. A patient or one with a patient's "informed consent" may inspect that patient's records at reasonable times, obtain copies of these records upon payment of reasonable costs, and receive copies of X-ray reports or have the X-rays referred, also upon payment of reasonable costs.

Physicians providing first services to a patient after April 30, 1980, are to provide a statement paraphrasing patient access rights to the patient. Physicians are to keep a log of patient access requests by time and date, person authorized to inspect the records, time and date of inspection, and identity of records inspected. ■

Patients' right of access to their medical records

A notice, which explains to patients the law requiring all physicians and hospitals to advise their patients of the patient's right of access to their medical record, is available to Society members for posting in their offices at a place easily seen by all patients. Patients may receive information from their record upon completion of an "informed consent" release form (see copy on preceding page). Write: State Medical Society of Wisconsin, Attn: Communications Coordinator, PO Box 1109, Madison, Wisconsin 53701; or phone (608) 257-6781 Madison area or 1-800-362-9080 in Wisconsin. ■

"DENIAL OF ACCESS" FORMS. These forms can be purchased from either of the following printers: Wisconsin Printing and Bank Supply, PO Box 637, Menomonee Falls, WI 53051 (ph 1-800-325-8094), or HC Miller Co, 224-226 East Chicago St, Milwaukee, WI 53202 (ph 1-800-242-9971). They are *not* available from the State Dept of Health and Social Services or the State Medical Society. ■

Denial of Researcher Access to Health Care Records

(Private Pay Patients Only)

State of Wisconsin, Department of Health & Social Services, HSS-0003

Patient's Name
Patient's Birthdate
Health Care Provider

Completion of this form is entirely optional. You do not have to sign this form to receive care or services. Please read the following points before deciding whether you wish to sign.

1) In order to perform studies of health care, researchers affiliated with your health care provider may wish to review your health care records. These researchers have a legal duty to keep your identity confidential and to make sure that information from your health care records is not given to anyone who is not connected with the research.
2) State law says that a private pay patient may choose to keep researchers from reviewing his or her health care records; this may be done by signing the Denial of Researcher Access statement below. Please feel free to discuss this matter with family, friends or an attorney.
3) If you decide to sign this form, you will need to sign a new form each year that you wish to deny access to your records.
4) If you sign this form and later change your mind and decide to let researchers review your health care records, you may cancel the Denial of Researcher Access statement below at any time by signing a written cancellation statement and giving it to your health care provider.

DENIAL OF RESEARCHER ACCESS TO HEALTH CARE RECORDS
(Private Pay Patients Only)

I have read the above information and understand that I do not have to sign this form to receive health care services. I understand that by signing this form, I will keep researchers from reviewing my health care records for a period of one year from the day I sign it. I also understand that I may cancel this statement at any time by signing a written cancellation statement. (S. 146.82 (2) (a) 6., Stats.)

Signature of Patient
(or Legal Guardian) _____ Date _____

Denial of Government Access to Health Care Records

(Private Pay Patients Only)

State of Wisconsin, Department of Health & Social Services, HSS-0002

Patient's Name
Patient's Birthdate
Health Care Provider

Completion of this form is entirely optional. You do not have to sign this form to receive care or services. Please read the following points before deciding whether you wish to sign.

1) State and federal law directs government agencies to make sure that doctors, nurses, hospitals, nursing homes and other health care providers give health care of good quality in a safe setting and protect patient rights.
2) To make sure that health care services meet the basic legal requirements, state and federal agencies may need to review patient health care records. These records tell agencies how patients have been treated and can be very important during any investigation of alleged poor care, patient abuse, fraud, or patient rights violations. These agencies have a legal duty to keep the records they review confidential.
3) State law says that a private pay patient may choose to keep state and federal agencies from reviewing his or her health care records; this may be done by signing the Denial of Government Access statement below. Please feel free to discuss this matter with family, friends or an attorney.
4) If you decide to sign this form, you will need to sign a new form each year that you wish to deny access to your records.
5) If you sign this form and later change your mind and decide to let state and federal agencies review your health care records, you may cancel the Denial of Government Access statement below at any time by signing the Cancellation Statement on the back of your copy of this form or your own cancellation statement and giving it to your health care provider.

DENIAL OF GOVERNMENT ACCESS TO HEALTH CARE RECORDS
(Private Pay Patients Only)

I have read the above information and understand that I do not have to sign this form to receive health care services. I understand that by signing this form, I will keep state and federal agencies from reviewing my health care records for a period of one year from the day I sign it. I also understand that I may cancel this statement at any time by signing the statement on the back of this copy or my own cancellation statement. (S.146.82(2)(a)5., Stats.)

Signature of Patient
(or Legal Guardian) _____ Date _____

(Note: If you are in a hospital or nursing home, a copy of this form will be sent to your private physician once it is signed.)

Use of consent and related forms for physicians

PREFACE. The forms referred to in this article are those which a physician may have occasion to use in his regular everyday practice. Since the forms were printed in the January 1970 "Blue Book" issue of the *Wisconsin Medical Journal*, they will not be reprinted here except for a few examples. Any physician wishing "sample" copies of these forms may obtain them upon request to the State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701; or telephone 257-6781 in the Madison area or toll-free in Wisconsin 1-800-362-9080. These forms will frequently need to be adapted for a particular situation. Each physician should review them carefully before using them to make sure that they reflect the realities of a specific situation.

The forms, as printed in the January 1970 "Blue Book" issue and as listed in the box below, and the text in this article have been prepared by legal counsel for the State Medical Society of Wisconsin, and reflect changes in the laws and courts in Wisconsin since the previous publication in January 1970.

The forms listed in the box below do not cover every possible situation where a consent should be obtained. Additional forms are contained in a publication of the American Medical Association called *Medico-legal Forms with Legal Analysis, 1979.* The Society attorneys suggest that any forms that a physician might wish to use outside of the forms referred to in this article be checked with the physician's personal attorney to determine their legal adequacy.

CONSENT FORMS FOR PHYSICIANS

FORMS WHICH A PHYSICIAN may have occasion to use in his regular everyday practice were printed in the January 1970 "Blue Book" issue of the WISCONSIN MEDICAL JOURNAL, and, therefore will not be reprinted here. Any physician wishing "sample" copies of these forms may obtain them upon request to the *Wisconsin Medical Journal,* PO Box 1109, Madison, Wisconsin 53701; or phone 608/257-6781. (Member physicians in Wisconsin may dial toll-free number: 1-800-362-9080.) Form numbers and titles as they appeared in 1970 are listed below for easy reference when requesting such forms. These forms will frequently need to be adapted for a particular situation. Each physician should read them carefully before using them to make sure that they reflect the realities of a specific situation.

Form 1: Letter to former patient where physician does not wish to treat later illness.
Form 2: Authorization to disclose information to new physician.
Form 3: Letter of withdrawal from case.
Form 4: Letter to confirm discharge by patient.
Form 5: Letter to patient who fails to follow advice.
Form 6: Letter to patient who fails to keep appointment.
Form 7: Statement of patient leaving hospital against medical advice.
Form 8: Provision for substitute physician at delivery.
Form 9: Consent to office treatment.
Form 10: Consent to examination of physician's records.
Form 11: Consent to taking of photographs.
Form 12: Consent to publication of photographs.
Form 13: Authority to admit observers.
Form 14: Consent to taking of motion pictures of operation.
Form 15: Consent to televising of operation.
Form 16: Statement of need for therapeutic abortion.
Form 17: Authorization to treat condition of recent or partial abortion.
Form 18: Artificial insemination homologous consent.
Form 19: Aid consent.
Form 20: Aid donor consent.
Form 21: Aid donor's wife consent.
Form 22: Consent to sterilization as a result of operation
Form 23: Consent to therapeutic sterilization.
Form 24: Consent to non-therapeutic sterilization.
Form 25: General consent to operation.
Form 26: Consent to operation.
Form 27: Consent to operation for cosmetic purposes.
Form 28: Consent to removal of tissue for grafting.
Form 29: Consent to operation and grafting of tissue.
Form 30: Order for taking of x-ray films.
Form 31: Consent to x-ray therapy.
Form 32: Permission to use radioisotopes.
Form 33: Consent to diagnostic procedure.
Form 34: Agreement for blood transfusion.
Form 35: Agreement for blood plasma transfusion.
Form 36: Agreement with blood donor.
Form 37: Release and receipt (blood donor).
Form 38: Agreement with blood donor.
Form 39: Release and receipt (blood donor).
Form 40: Consent to disposal of amputated part of organ.
Form 41: Gift of part of body under Wisconsin Uniform Anatomical Gift Act of 1969.
Form 42: Authorization for tissue donation.
Form 43: Authorization for autopsy and tissue donation.
Form 44: Authorization for autopsy.
Form 45: Consent to disposal of body.

Finally, the forms do not cover those procedures which are normally done in a hospital. The Wisconsin Hospital Association has a publication entitled *Consent Manual, 1981.* All member hospitals of that Association have the manual. Those forms cover hospital situations, whereas this article is concerned primarily with the physician in his regular practice.

I. WHAT IS CONSENT

Consent, in the context that we are using it, means permission from a patient or his legal representative, to a physician to diagnose and treat the patient.

a. Informed consent

To be legally valid, consent must be given by the appropriate person (see II. *Who Can Consent,* below) and this consent must be given with appropriate understanding of the nature of the treatment and the risks associated with it. This has been the law of the United States and Wisconsin for many years; and the courts have held the physician liable for treatment without proper consent, even when the treatment worked and the results were good. Treatment without consent is actionable and is the easiest form of suit against a physician because no expert testimony or evidence is needed and historically the burden has been on the physician to prove that he or she proceeded only with proper patient consent.

Under Wisconsin law you must disclose to the person giving consent such information as is necessary under the circumstances to enable a reasonable person under those circumstances to intelligently exercise his right to consent to or refuse treatment. The disclosure must be made in terms understandable to the person giving consent and need not include disclosure of matters already known to the person or risks which are extremely remote possibilities.

This rule leaves broad areas of professional judgment to the physician but requires disclosure of all matters that would be relevant to a reasonable person to permit him to make an intelligent decision to consent to or refuse the recommended treatment.

In addition recent Wisconsin statutes and administrative rules require that the patient be informed about available alternate methods of treatment. The law is as follows:

Chapter 375, Laws of 1981

AN ACT to amend 448.02(3) (intro.) and 448.40; and to create 448.30 of the statutes, relating to requiring physicians to inform their patients of alternate modes of treatment, granting rule-making authority and creating a penalty.

448.02(3) Investigation; hearing; action. (intro.) The board shall investigate allegations of unprofessional conduct by persons holding a license or certificate granted by the board. A finding by a panel established under s. 655.02 or by a court that a physician has acted negligently is an allegation of unprofessional conduct. *An allegation that a physician has violated s. 448.30 is an allegation of unprofessional conduct.* After the investigation, if the board finds that there is probable cause to believe that the person is guilty of unprofessional conduct, the board shall hold a hearing on such conduct. The board may, when it finds a person guilty of unprofessional conduct, warn or reprimand that person, or limit, suspend or revoke any license or certificate granted by the board to that person. The board shall comply with rules of procedure for such investigation, hearing and action promulgated under s. 440.03(1).

448.30 Information on alternate modes of treatment. Any physician who treats a patient shall inform the patient about the availability of all alternate, viable medical modes of treatment and about the benefits and risks of these treatments. The physician's duty to inform the patient under this section does not require disclosure of:

(1) Information beyond what a reasonably well-qualified physician in a similar medical classification would know.
(2) Detailed technical information that in all probability a patient would not understand.
(3) Risks apparent or known to the patient.
(4) Extremely remote possibilities that might falsely or detrimentally alarm the patient.
(5) Information in emergencies where failure to provide treatment would be more harmful to the patient than treatment.
(6) Information in cases where the patient is incapable of consenting.

Also see page 24 for complete rule on alternate modes of treatment.

The forms, as printed in January 1970, and other standard forms which you may use generally do not provide for a full description of the disclosures given, either as to treatment or risks involved. You should make some provision in your patient records to indicate specifically what disclosures were made. Some physicians tape record their disclosures and retain these tapes with the patient records. Some who are involved in the same procedure frequently use prepared statements covering the treatment and its risks and obtain receipts for copies of this information. Some give disclosures in front of witnesses and have their notes on the matters disclosed initialed or countersigned by the witnesses. For your protection you should have some record of the matters disclosed in each situation.

b. Implied consent

There are situations where the consent of the patient does not have to be in writing or even expressed orally. This is implied consent.

A classic example of implied consent is the unconscious victim of an automobile accident where immediate action needs to be taken to save the life of the patient or at least to minimize the effect of his injuries. In this emergency situation consent is im-

plied. The courts say that if the patient had been conscious he would have given consent to save his life and, therefore, the physician will not be penalized for doing what he would have been allowed to do if the patient had been conscious.

II. WHO CAN CONSENT

Persons who are adults and are competent to understand what the physician is proposing to do, why it is necessary or desirable, and what the risks of doing it are going to be, can give a consent.

a. Minors

In Wisconsin, persons under the age of 18 are minors.

The proper person to consent to surgery or other treatment of a minor is either parent, or if neither parent is living, the minor's court appointed guardian. A physician is not legally protected by a consent signed by a relative of a minor, other than a parent, unless the relative has been appointed as the minor's legal guardian by a court.

There are two exceptions to the above general rule. First, in an emergency, a consent is not necessary if the parents or guardian cannot be located, and, in the judgment of the physician in charge and, of consultants where consultation is practical, immediate treatment is necessary to save life or to prevent the deterioration or aggravation of the condition of the patient.

The legal reason for the above exception is that in an emergency the law implies the consent of the patient, or in the case of a minor, of his parent or guardian. Because the law does not imply consent beyond the treatment actually necessary to meet an emergency, the physician may safely treat only the emergency condition itself, and nothing else, without actual consent of a parent or guardian.

Second, an emancipated minor can give a consent for medical treatment, including surgery. A minor is emancipated (1) who is lawfully married, or (2) whose parents have divested themselves of their legal right of control over him. Typically a minor in the latter situation is one who is self-supporting. An unmarried minor attending school away from his home community is not emancipated by virtue of that fact alone.

A physician who has any doubt whether a minor is emancipated, should require the consent of a parent or the legal guardian before proceeding with non-emergency treatment.

b. Incompetents

Physicians, above all others, are qualified to determine whether a person is competent to sign a consent. If a patient is incompetent, a consent by the patient will not be any protection. For incompetents other than minors, consent can only be given by the person's legally appointed guardian, except in emergencies. Courts in Wisconsin have very limited powers to substitute their discretion for that of a person's legally appointed guardian.

c. Persons under the influence of drugs or intoxicants

Unless there is an emergency situation, the physician should either wait until the influence of the drug or intoxicant passes, or, make appropriate contacts for the appointment of a guardian. In the case of an emergency, treatment necessary to save life can be given.

III. WHY CONSENTS

In Wisconsin failure to obtain informed consent for medical treatment is the negligent violation of a legal duty. As a result of this, a physician may be sued for a species of malpractice. In other states, and under earlier case law in Wisconsin, treatment without consent was treated as a form of assault and subject to civil, and possibly criminal, liability on that basis. It is possible that in an aggravated situation, where the physician has obtained no consent or where his treatment has gone beyond the consent given, courts would still act on the assault rather than the negligence basis. In most cases, however, it should be anticipated that the question will be whether informed consent was given and failure of the physician to obtain consent based on an adequate explanation of the treatment and its possible risks is a form of negligent malpractice.

In an action for failure of informed consent, the patient has the responsibility for proving failure of disclosure by the physician, lack of knowledge by the patient of the nature of the treatment and its risks, and the adverse effects of the treatment. The physician, by way of defense, may prove reasons why no disclosure was given, these defenses to be based on the "reasonable person" rule discussed above. No expert testimony is required to assist the jury in determining whether the failure of disclosure led to consent to the treatment, or phrased another way, whether adequate disclosure would have resulted in the patient's refusing the treatment.

A few minutes spent preparing, explaining, and obtaining the consent signed by the patient and making appropriate notes in the patient records can save untold hours of time, money, and embarrassment for the physician.

IV. CONSENTS LIMITED

A word of caution needs to be set forth. A valid consent must not be too broad. It cannot be a general consent for the physician to do anything he wants to do. It should be limited to the specific situation presented by the diagnosis of the patient's illness. Finally, a consent is not effective if the treatment or procedure consented to is illegal, is contrary to public policy or, is given by a person who had no legal right to give it.

V. CONSENT AND RELATED FORMS

The text and suggestions that follow are related to the numbered forms as printed in the January 1970 "Blue Book" and as listed elsewhere in this issue. Physicians should read the text and suggestions prior to attempting to use or adapt a particular form.

PHYSICIAN AND PATIENT

1. Contract for services

The physician-patient contract is established when the physician, in response to an express or implied request to treat the patient, undertakes to render professional services to him. It is not necessary to have a formal written contract. The contract between the patient and physician is implied and is enforceable. If you wish, you may restrict your services to one procedure, one treatment or treatments at a particular time or place. This can be done by a letter requesting the patient to sign and return a copy to you. No form has been included for this situation. A physician need not accept every person who wishes services. He can accept patients as he wishes. Further, specialists need not accept patients who have illnesses outside their specialty.

However, once the patient-physician relationship has been entered into the physician is under an obligation to treat the patient until the relationship is terminated.

2. Termination of contract

Care must be taken to inform the patient appropriately, but unmistakably when the patient-physician relationship is terminated. What should be done depends upon how the situation arises.

a. Former patient

If you have a former patient who calls and wishes further services, and you do not wish to further treat that patient, you should make your decision clear. Following such conversation you should confirm it by a letter. Form 1, with its enclosure, Form 2, is appropriate and gives the physician a record for his file. (These forms appear as "examples" on this page.)

b. Withdrawal from a case

There may be occasions where a physician does not wish to continue on a case. Consistent with legal as well as ethical principles he must find appropriate steps to withdraw. He cannot just stay away and not notify the patient. This would be abandoning the patient and could subject the physician to a suit for damages.

He must give the patient proper notice that he is withdrawing from the case and must give the patient

FORM 1

LETTER TO FORMER PATIENT WHERE PHYSICIAN DOES NOT WISH TO TREAT LATER ILLNESS

Dear _____:

This letter is to confirm our conversation of _____ _____ (date).

At that time I informed you that I could not accept you as a patient for your present illness. I suggested to you that you contact another physician and I urge you to do so now if you have not already done so.

Since I have treated you for a previous condition, I have records which your new physician can use. Upon receipt of your written approval, I will make available to your new physician your case history and complete information regarding the diagnosis and treatment which you have received from me.

For your convenience I enclose a form that you may use to give me such written approval.

Very truly yours,

_____M.D.

(Enclose Form 2)

FORM 2

AUTHORIZATION TO DISCLOSE INFORMATION TO NEW PHYSICIAN

I authorize _____, M.D., my former physician, to disclose complete information to my present physician, _____, M.D., concerning medical findings and treatment from about _____ 19____ until the date of this authorization.

Signed _____

Place _____

Date_____

Witness _____

Witness _____

FORM 3

LETTER OF WITHDRAWAL FROM CASE

Dear Mr. _____:

I find it necessary to inform you that I am withdrawing from further professional attendance upon you for the reason that you have persisted in refusing to follow my medical advice and treatment.

Since your condition requires medical attention, I suggest that you place yourself under the care of another physician without delay. If you so desire, I shall be available professionally to attend you for a reasonable time after you have received this letter, either for regular or emergency medical treatment, but in no event for more than _____ days following such receipt. This should give you ample time to select a physician of your choice from the many competent practitioners in this area.

With your written approval, I will make available to this physician your case history and complete information regarding the diagnosis and treatment which you have received from me.

Very truly yours,

_____, M.D.

Enclosure Form 2

a reasonable amount of time to obtain a new physician. What is a reasonable amount of time will depend upon the circumstances of the case and the availability of other physicians in the area. We suggest that under most circumstances that the time set forth be not less than five (5) days. To provide a record and protect the physician a letter should be sent to the patient. If the letter is sent by certified mail with a return receipt requested, the physician will have record in his file showing not only that the patient was notified, but also the date the patient received the notification. Form 3 (example below) is appropriate for this purpose. We suggest that you may wish to enclose Form 2 with the letter for the patient's convenience.

c. Discharge of a physician

The patient may also terminate the contract by discharging the physician. The physician will want to make an immediate and adequate record that he did not abandon the patient. The physician may do well to try to obtain from the patient a signed statement of the facts and discharge of the physician. Where this is not available we suggest that the physician send a letter to the patient such as Form 4. Again, the enclosure of Form 2 is appropriate. We suggest the letter be sent by certified mail, with a return receipt requested so that your file will show receipt of the letter by the patient.

3. Special problems during treatment

There are many problems that can arise during the treatment of a patient. The ones covered in this section are of particular importance to the physician since, if no protective steps are taken and a record made of such steps, the defense against allegations of malpractice could be made considerably harder and more expensive.

a. Patient who fails to follow advice

Where a physician feels that a certain treatment or procedure should be done and the patient refuses, a record should be made. Form 5 may be adapted to the situation as it occurs.

b. Patient who fails to keep appointment

If a patient fails to keep an appointment where the patient has a condition the physician knows needs treatment, the physician should make this fact known to the patient. The physician, at the same time, should see that his records reflect his professional advice to the patient. A letter such as Form 6 should be sent to the patient.

FORM 4

LETTER TO CONFIRM DISCHARGE BY PATIENT

Dear Mr._____:

This will confirm our telephone conversation of today in which you discharged me from attending you as your physician in your present illness. In my opinion your condition requires continued medical treatment by a physician. If you have not already done so, I suggest that you employ another physician without delay. You may be assured that, at your written request, I will furnish him with complete information regarding all medical facts, diagnosis, and treatment which you have received from me.

Very truly yours,

_____, M.D.

Enclosure Form 2

FORM 5

LETTER TO PATIENT WHO FAILS TO FOLLOW ADVICE

Dear Mr. _____:

At the time that you brought your son, William, to me for examination this afternoon, I informed you that I was unable to determine, without X-ray pictures, whether a fracture existed in his injured right arm. Although I insisted and still do insist that an X-ray study should be made of William's arm, you have refused to follow my advice. I strongly urge you to permit me or some other physician of your choice to make this X-ray examination without further delay.

Your refusal to permit a proper X-ray examination to be made of William's arm may result in serious consequences if, in fact, a fracture does exist.

Very truly yours,

_____, M.D.

FORM 6

LETTER TO PATIENT WHO FAILS TO KEEP APPOINTMENT

Dear Mr. _____:

On _____, 19_____, you failed to keep your appointment at my office. In my opinion your condition requires continued medical treatment. If you so desire, you may telephone me for another appointment, but if you prefer to have another physician attend you, I suggest that you arrange to do so without delay. You may be assured that, at your request, I am entirely willing to make available my knowledge of your case.

I trust that you will understand that my purpose in writing this letter is out of concern for your health and well-being.

Very truly yours,

_____, M.D.

c. Patient who leaves hospital against medical advice

Cases arise where patients refuse to remain in a hospital even though their physician feels that continued hospitalization is necessary. Form 7 (example below) provides a statement that the patient may sign which will release liability for the patient's acts. The physician should have two witnesses with him at the time he informs the patient of the reasons the physician feels indicate the need for continued hospitalization. These witnesses should sign the form whether the patient signs the form or not. If the patient refuses to sign, that fact should be noted on the form. The physician should have a copy of the form for his office records. The hospital will also want a copy for its records.

d. Substitute physician in obstetrical cases

It is not unusual for a physician to be unable to be present at a delivery, even though the physician would wish to be there. Another delivery might be in progress or the speed of delivery might make it impossible for the physician to get to the place of delivery. The physician should explain this to his obstetrical patient when she first comes to his offfice. The physician should have the expectant mother sign a form such as Form 8 as an acknowledgment of the fact that she understands and agrees.

FORM 7

STATEMENT OF PATIENT LEAVING HOSPITAL AGAINST MEDICAL ADVICE

This is to certify that I am leaving _____ Hospital at my own insistence and against the advice of my attending physician and hospital authorities. I have been informed by them of the dangers attendant on my leaving the hospital at this time. I assume all responsibility for any results caused by leaving the hospital prematurely, and I hereby release my attending physician and the hospital, its employees and officers from all liability for any and all conditions, complications and results.

_____

I hereby agree to hold harmless my attending physician and the _____ Hospital, its employees and officers, from all liability of whatsoever nature, with reference to the discharge of the patient named above.

_____
(husband, wife, parent, etc.)

Date _____
Signed in the presence of:
Witness _____
Witness _____

NOTE: If the patient refuses to sign such a statement, he cannot be forced to do so, legally, nor may his release be withheld until he signs. If this occurs, the form should be filled out, witnessed by the hospital personnel present, and the statement made on the form "signature refused."

e. Office treatment

Some procedures can be done either in the physician's office or in the hospital. Where the physician decides to do the procedure in his office he should inform the patient of the alternatives and any special risks involved. If the patient decides that the procedure should be done in the hospital, the physician should not attempt to do the procedure in his office. If the patient does agree to having the procedure in the office, then the physician should have the patient sign a consent such as Form 9.

4. Confidential and privileged relationship

In Wisconsin, communications between a patient and his physician are protected both by law and ethics.

Under Wisconsin law, certain disclosures made by a patient to his physician in order to give the physician sufficient information to enable him to treat the patient are "privileged." This "privilege" means that the statements cannot be disclosed by the physician unless the patient allows it or unless the physician is allowed or required by law to disclose them. The "privilege" is that of the patient, and can ordinarily be claimed or released only by the patient.

Confidential communications involve a physician's ethical duty to keep secret the information he has obtained about a patient while acting in his professional capacity. This obligation is independent of the privilege discussed in the preceding paragraph. It is binding on the physician at all times.

Wisconsin Statutes permit the right of an employee or the employee's designated representative to

FORM 8

PROVISION FOR SUBSTITUTE PHYSICIAN AT DELIVERY

Date _____
Place _____

To Dr. _____:

In engaging you as my obstetrician, I understand that if you are unavailable or unable for any reason to be present and to deliver me, at the time of my confinement, you will make a reasonable effort to refer me to another duly licensed physician to render obstetrical care. I agree to hold you free from any duty, liability or responsibility in connection with any services that may be performed by any physician to whom you refer me or whom I may call.

Signed _____
(wife)

_____
(husband)

Signed in the presence of:
Witness _____
Witness _____

NOTE: If the husband is present at the time that the arrangements are made, it is desirable that he should witness his wife's execution of this form and sign the form too.

inspect personal medical records concerning the employee contained in the employer's file. If the employer believes that disclosure of an employee's medical records would have a detrimental effect on the employee, the employer may release the medical records to the employee's physician or through a physician designated by the employee, in which case the physician may release the medical records to the employee's immediate family.

Unauthorized disclosure of confidential information can be grounds for revocation of the physician's license. It may also be the basis for a suit for damages by the patient. Each physician therefore must exercise care to protect against unauthorized disclosure of confidential or privileged information.

a. Release of patient health care records

By earlier case law and now by statute, a patient's health care records (all records related to the health of a patient prepared by or under the supervision of a health care provider) may ordinarily only be released on the authorization of the patient or one legally permitted to act for the patient. The law defines "informed consent" with respect to the disclosure of information from a patient as written consent "containing the name of the patient whose record is being disclosed, the purpose of the disclosure, the type of information to be disclosed, the individual, agency or organization to which disclosure may be made, the type of health care providers making the disclosure, the signature of the patient or the person authorized by the patient, the date on which the consent is signed and the time period during which the consent is effective." Wis. Stats. §146.81 (2). In making a release of medical records, the physician should very carefully review the authorization to assure that the release is made strictly in accordance with the authorization.

(1) Access without informed consent. Release of medical records without patient authorization, unless specifically permitted by law, is a breach of confidentiality and may subject the physician to a lawsuit. The law permits the release of patient health care records upon request without informed consent in the following circumstances:

(a) To staff, accreditation or review committees.

(b) For performance of healthcare services to persons providing such services (including emergency care) or being consulted in regard to such services.

(c) For billing, collection, and payment of claims.

(d) Under court order.

(e) On written request from an appropriate government agency.

(f) For research purposes under specific conditions.

(2) Patient access to health care records. Any patient or other person may, upon submitting a statement of informed consent, (a) inspect the patient's records during regular business hours upon reasonable notice, (b) receive a copy of the patient's records on payment of reasonable costs, (c) receive a copy of the patient's x-ray reports or have the patient's x-ray films referred to a provider of his choice for analysis upon payment of reasonable costs. Wis. Stats. §146.83.

b. Photographs

Physicians may wish to make a visual record of a case for several reasons. In cosmetic surgery it may show the result of the surgery. In other cases it may show the result of a particular method of treatment. It may also be used for unusual cases where documentation would be valuable for teaching purposes. In any of these cases there must be a release of the confidential or privileged relationship to allow the taking of photographs.

c. Observers, motion pictures, television

In cases similar to those where photographs may be desirable, there are cases which should be observed, televised or recorded on film. The release of the confidential or privileged relationship must also be obtained in these cases. Forms 13, 14 and 15 may be used for these situations.

VI. SPECIAL SITUATIONS

There are certain procedures which the physician should approach with caution and be sure to take the necessary steps to document what has happened and, to be sure that he proceeds only with proper authority and consent. These include:

1. **Abortions**
2. **Artificial insemination**
   - *a. Homologous*
   - *b. Donor*
3. **Sterilization**
   - *a. Sterilization as a result of an operation for other purposes*
   - *b. Therapeutic sterilization*
   - *c. Nontherapeutic sterilization*

VII. OTHER CONSENT FORMS

There are other forms included in the January 1970 "Blue Book" printing that may be of common use to a physician. These forms are believed not to require explanatory text. However, before any of these forms are signed, the physician should review the requirements for a valid consent given earlier in this article. ■

Some considerations before opening a physician's practice

WHEN BEGINNING a medical practice, whether starting a new one or joining an existing group, there are many matters that should be considered before seeing your first patient. The following check list has been developed to itemize major tasks or decisions a physician should consider prior to that time. Depending upon the type of practice, some may not apply; however, if this list is used, the majority of items will be covered.

- ☐ *Discuss practice location with spouse* (type of community desired, location, size, hospitals, school system, cultural opportunities).
- ☐ *Office facilities* (rent—negotiate lease; own—negotiate and close purchase).
- ☐ *Determine office layout and size.*
- ☐ *Furniture and equipment* (office—chairs, desks, calculators, computer; waiting room—chairs, tables, lamps; examining room—desk, chairs, exam table, medical equipment and supplies).
- ☐ *Obtain license to practice medicine.*
- ☐ *Obtain federal narcotics number.*
- ☐ *Develop employment contract.*
- ☐ *Partnership agreement or service corporation articles.*
- ☐ *Hospital staff privileges.*
- ☐ *Choose advisors* (accountant, lawyer, banker, management consultant, insurance agent, real estate broker, investment counsel).
- ☐ *Obtain necessary insurance coverage* (business—professional liability, Workers' compensation, general liability, umbrella [business/personal], employee fidelity bond; personal—health, life, disability income/income protection, home owners, auto).
- ☐ *Determine office hours based on community needs.*
- ☐ *Apply for federal and state employer identification numbers (EIN).*
- ☐ *Apply for federal and state unemployment compensation tax ID numbers.*
- ☐ *Determine support staff needed, interview and hire.*
- ☐ *Obtain necessary financing.*
- ☐ *Develop financial systems* (determine fees, accounting system, billing, system, statement format, collections and receivable management, consider credit card payments by patients, internal controls).
- ☐ *Announcements to local physicians, pharmacists, general public* via newspaper, telephone directory, individually mailed announcements and calling and appointment cards.
- ☐ *Open checking account(s).*
- ☐ *Learn community resources* (hospitals, schools, pharmacies, social services, rehabilitation services).
- ☐ *Arrange for utilities* (telephone, electricity, gas/oil, water).
- ☐ *Telephone answering service.*
- ☐ *Arrange for coverage during off hours.*
- ☐ *Order necessary office forms* (letterhead, envelopes, RX forms, accounts receivable statements, third-party claim forms or HCFA-1500 claim forms).
- ☐ *Arrange for lab and x-ray services.*
- ☐ *Obtain good debt collection service.*
- ☐ *Repay student loans on timely basis.*
- ☐ *All employees must complete federal Form W-4 and state Form WT-4* (withholding allowance certificates).
- ☐ *Memberships* (become involved in: county and state medical societies, AMA, specialty societies, local service or business groups, hospital staff activities).

The AMA has a regular schedule of "Starting Your Own Practice" workshops which also provide much information on this subject.

This checklist is intended to provide the most common matters a physician should consider when starting a practice. It is not inclusive in every instance since individual circumstances require attention to matters unique to that situation.

Physicians may also contact the State Medical Society in Madison for additional information: (608)257-6781, or toll-free in Wisconsin 1-800-362-9080. Office location: 330 East Lakeside St, Madison 53715 (Lakeside Street intersects John Nolen Drive at the signal lights just before crossing the "causeway" over Lake Monona to Downtown Madison, from the South Beltline near the Coliseum).

"Blue Book" good reference source

Whether opening a practice for the first time or moving a practice to Wisconsin, physicians will find valuable information in the annual "Blue Book" issue of the *Wisconsin Medical Journal,* the official publication of the State Medical Society of Wisconsin. This is a reference source on medicolegal, socioeconomic, legislative, governmental matters of direct concern to the physician. It also is a reference source on State Medical Society organizational structure, other related organizations, and state government agencies.

To obtain a copy contact the *Wisconsin Medical Journal,* PO Box 1109, Madison, Wis 53701, or phone State Medical Society offices in Madison as noted above. ■

Some considerations in the closing of a physician's practice

WHILE THERE ARE NO formally slated rules for closing a medical practice, there are several important items which should be considered and planned in advance. The list given below is not complete but the State Medical Society of Wisconsin believes it will be helpful.

1. Notification of patients

Patients should be given adequate notice, a minimum of three months is suggested, in writing that you plan to close your office and on what date so that they will have sufficient time to obtain another physician. It is also suggested that, in the letter of notice to the patients, you enclose a form for the patient to sign authorizing the release of records should they wish to request that a copy of their records be sent to the new physician of their choice. A list of all patients notified should be retained in your files.

You can save postage, in the case of current patients, by inserting the letter with a monthly statement or billing; letters to other patients will have to be mailed separately.

You also may wish to place an announcement in one or more local newspapers.

2. Retention of medical records

(a) Medical records, including case histories, treatment records, x-rays, laboratory reports, correspondence with physicians and others, should not be destroyed until the statute of limitations has expired with regard to each patient. This is because the physician's record and liability insurance policies could be your chief source of defense in a future law suit.

The Statute of Limitations has been revised to allow actions involving adults to be initiated within three years of the occurrence or one year from discovery of the injury but not later than five years from the occurrence. Actions involving minors are bound by this limitation, or age 10 years, whichever is later. Possession of the policy will be invaluable or you may face the defense alone at your own expense.

(b) The patient has a general right to know what is in his medical records and thus you should make it known where such records can be obtained. Such records generally should not be given to the patient, but should be forwarded to another physician of the patient's choice with the consent and at the request of the patient, in writing.

(c) The Wisconsin Statutes relating to the examination or inspection of medical records on patient authorization read:

"**804.10 (4).** Upon receipt of written authorization and consent signed by a person who has been the subject of medical care or treatment, or in case of death of such person, signed by the personal representative or by the beneficiary of an insurance policy on the person's life, the physician or other person having custody of any medical or hospital records or reports concerning such care or treatment, shall forthwith permit the person designated in such authorization to inspect and copy such records and reports. Any person having custody of such records and reports who unreasonably refuses to comply with such authorization shall be liable to the party seeking the records or reports for the reasonable and necessary costs of enforcing the party's right to discover."

3. Disposal of drug stocks

The Regional Administrator of the Drug Enforcement Administration, Chicago, Illinois, has jurisdiction over the State of Wisconsin with regard to disposal of unused controlled substances. The following procedure has been approved as a guide to physicians:

"The physician's DEA number (Controlled Substances Registration Certificate), unused Government order forms and controlled drugs should be disposed of as soon as possible. The registration certificate and unused Government order forms (DEA-222 c) should be returned to the Drug Enforcement Administration, 219 South Dearborn, Suite 500, Chicago, Illinois 60604. Procedures for destruction of controlled substances may be obtained by calling the Chicago Divisional Office.

Forms and additional information may be obtained from the Drug Enforcement Administration, Chicago Divisional Office, 219 South Dearborn, Suite 500, Chicago, Illinois 60604 (312) 353-7875.

4. Sale of medical practice

(a) If you are selling your practice, you should make certain that the buyer is a physician licensed, or eligible to be licensed, in Wisconsin. This information can be obtained from the State Medical Society or the Wisconsin Department of Regulation and Licensing.

(b) Records relating to patients should not be sold. However, the sale may include, as one of its terms, unlimited access to the records of those patients who seek the services of the purchasing physician.

5. Keeping your license in force

You may wish to keep your license in force and register each year in the event that you wish to do some consultation work or are called upon to perform some act of medical practice in an emergency. If you elect to keep your license in force, you will be required to continue to meet the continuing medical education requirements. This requirement calls for 30 hours of Category I credit as defined in the Physician's Recognition Award of the American Medical Association, to be accumulated every two years. The Medical Exam-

ining Board requires this regardless of extent or nature of practice; there are no exceptions due to age or retirement.

6. Malpractice insurance

Your policy should be examined to determine whether it is written on an OCCURRENCE or a CLAIMS MADE basis. Consult your insurance agent. If the policy is written on a CLAIMS MADE basis, only those claims made while the policy is in force will be covered and you should either continue your coverage or purchase coverage extension to protect you until all statutes of limitation have run.

7. Accounts receivable

Not all of your patients will have paid their bills by the time your practice is closed. It will be necessary to have someone available to accept, record, and deposit payments received after the official closing of your practice. You may wish, after a suitable waiting period of three or four months, to turn those accounts still unpaid over to a reputable collection agency.

8. Continuation of SMS membership

We hope that you will continue to be active in organized medicine. The State Medical Society urges all physicians who are retired or will be retiring to advise their county or state society of their present or future status so that an appropriate change in classification can be arranged.

9. Income taxes

Copies of your income tax returns and all supporting documentation, including ledgers and accounting records, should be preserved until the Internal Revenue Service can no longer assess additional tax. For Federal returns filed on time and containing all correct and pertinent data, this is usually three years; for returns where gross income has been understated by 20 percent or more, it is six years; for fraudulent returns or where no return has been filed there is no time limit.

10. Payroll taxes

Final returns and payments of all Federal and state withholding and Social Security taxes must be made after the last employee has been terminated and the last payroll paid.

Finally, it is recommended that you work closely with your attorney or business manager particularly on the tax aspects of closing your practice.■

Narcotics

Annual Registration

A physician who desires to dispense, administer, or prescribe any controlled drug substance is required to have a Drug Enforcement Administration number (DEA no.). The initial registration application may be obtained from the Chicago Divisional Office. The Divisional Office of DEA in Chicago has informed the State Medical Society that DEA Headquarters will then mail a renewal application to each physician approximately 45 days before the expiration date found on the certificate.

Change of Residence

If you move, or change your place or places of business, you must notify the Drug Enforcement Administration, Registration Branch, 219 South Dearborn, Suite 500, Chicago, Illinois 60604.

In Case of Death

The Regional Director, Drug Enforcement Administration, Chicago, Illinois, who has jurisdiction over the State of Wisconsin with respect to these matters, approved the following procedure in a communication to the State Medical Society:

> "The deceased physician's DEA number (Controlled Substances Registration Certificate), unused Government order forms and controlled drugs should be disposed of as soon as possible. The registration certificate and unused Government order forms (DEA-222 c) should be returned to the Drug Enforcement Administration, 219 South Dearborn, Suite 500, Chicago, Illinois 60604. Procedures for destruction of controlled substances may be obtained by calling the Chicago Divisional Office."

Forms and additional information may be obtained from the Chicago Divisional Office:

Drug Enforcement Administration
Chicago Divisional Office
219 South Dearborn, Suite 500
Chicago, Illinois 60604
Telephone: (312) 353-7875

Preprinted Prescription Blanks

The Justice Department, Drug Enforcement Administration, reports that neither Federal law nor administrative regulations prohibits the printing of the physician's narcotic registration number on prescription blanks.■

What to do when a physician dies

FOLLOWING THE LOSS of one of its members by death, it has long been the practice of the State Medical Society to write the physician's spouse or next of kin in an effort to provide some advice during a trying period. The Society, believing that "an ounce of protection is worth a pound of cure," suggests that every member give thoughtful consideration to some of the problems which are likely to face a physician's spouse or next of kin. Careful preparation for such eventualities not only protects the family, but eases its burdens at a trying time.

Following the death of a physician, the spouse or next of kin will be faced with many decisions involving the settlement of the business affairs relating to the deceased physician's practice. It is of extreme importance that the spouse or next of kin act upon the advice of an attorney. When practical it is recommended that physicians acquaint their spouses or next of kin with legal and other advisors and some of their business affairs. This will provide an established working business relationship between the spouse or next of kin and the advisors for that eventuality when they are called upon to act. Some of the chief problem areas the spouse or next of kin will face are outlined in the remainder of this article.

Former patients may seek a continuation of medication prescribed by the deceased physician. This must never be permitted except on advice of another physician because of the possibility of rapid change in the condition of the patient and resultant possible cause for legal action in the event unexpected results stemmed from continued use of the medication.

The spouse or next of kin also will be presented with the problem of what to do with the physician's narcotics. The Regional Administrator of the Drug Enforcement Administration, Chicago, Illinois, has jurisdiction over the State of Wisconsin with regard to disposal of unused controlled substances. The following procedure has been approved as a guide to physicians:

"The physician's DEA number (Controlled Substances Registration Certificate), unused Government order forms and controlled drugs should be disposed of as soon as possible. The registration certificate and unused Government order forms (DEA-222 c) should be returned to the Drug Enforcement Administration, Registration Branch, 219 South Dearborn, Suite 500, Chicago, Illinois 60604. Procedures for destruction of controlled substances may be obtained by calling the Chicago office; tel (312) 353-7889.

It is important that a spouse, other members of the family, and the attorney see to it that there is full and prompt compliance with the requirements of the above communication.

Records relating to patients, including case histories, treatment records, x-rays, laboratory reports, correspondence with physicians and others should not be destroyed for at least six years after the physician's death. Liability for malpractice and some other claims do not cease upon the death of a physician.

The physician's records and liability insurance policies may be the spouse or next of kin's chief sources of defense. Every precaution should be taken to insure that all such basic materials are kept intact and subject to immediate call for at least six years. The family attorney will be able to tell when they are no longer needed for this purpose.

The spouse or next of kin can expect that the deceased physician's patient will seek care elsewhere unless the physician had one or more associates. Sometimes the new physician will find it necessary for adequate treatment to obtain a copy of the previous physician's record of care of a patient. In such event, it is wise to insist upon a written request from the patient and the new physician. A copy of the record, with a covering letter may then be sent. A copy of the forwarding letter should be inserted in the original patient's file for future reference.

A decision may be made to sell the deceased physician's practice. The items to be included in the sale will vary with the nature of the practice, the amount of equipment involved and the wishes of the buyer.

To avoid complications, the spouse or next of kin should make sure the buyer is a physician licensed in Wisconsin. This information can be obtained from physician acquaintances or the State Medical Society. Records relating to patients should not be sold. However, the sale may include, as one of its terms, unlimited access to the records of those patients who seek the services of the purchasing physician. The spouse or next of kin's legal and other advisors can best inform them how to arrange the sale.

The collection of the deceased physician's professional accounts is another important matter. The spouse and/or next of kin should carefully follow their attorney's advice before bringing suit, since a patient can counterclaim for malpractice within three years. Ordinarily it is not desirable for a spouse or the heirs to enforce collection by suit within such period. They should also seek legal and accounting advice on

Liability for malpractice and some other claims do not cease upon the death of a physician. Liability suits can be quite traumatic for the surviving spouse and family, especially if they should occur shortly after the physician's death. Some insurance company-appointed attorneys have been known to provide little advice or counseling to surviving spouses and next of kin who in a state of bereavement may be fearful of attorneys whom they have never known before. Should surviving family members have questions concerning liability matters, they are urged to contact the State Medical Society.

how long to retain the financial records of the deceased physician. It is quite possible that the estate may be subjected to audit by the state or federal income tax authorities. The retention of complete records is essential in anticipating such possibility.

A spouse and/or next of kin should consult their attorney as to whether the estate needs to arrange a malpractice policy buy-out with the deceased physician's carrier so as to protect the estate assets and the heirs' share of such assets. Some physicians will have attempted to do this during their lifetime and if they did so this will be evident from study of the policy, its endorsements and correspondence. If there is uncertainty in the matter, the attorney should contact the insurance carrier and seek its cooperation in ascertaining the facts. The reason for this is that a suit can be maintained against the estate and heirs of a deceased physician who is alleged to have committed one or more acts of professional negligence with resultant injury to a patient.

The State Medical Society office is always available for consultation with a spouse, the family, or the estate attorney.■

How to get healthcare information in Wisconsin

THE WISCONSIN HEALTH Sciences Library Network, a network of libraries that blanket the state, stands ready to put Wisconsin health-care practitioners in touch with information in libraries throughout the country.

Any practitioner needing such information should first contact the library in his or her institution. If the person is an independent practitioner or the institution has no library, another local hospital or clinic should be contacted. Many such libraries will now serve people who are not among their primary clientele. A great number of these libraries are now organized into resource-sharing consortia and can get a needed item quickly even if they do not have it in their own collection. The libraries are also eligible to forward requests to the two Wisconsin resource libraries—in Madison (the UW Middleton Health Sciences Library) and in Milwaukee the Todd Wehr Library (Medical College of Wisconsin). The local libraries are likely to have the tools to identify which other library has the needed information.

If no local library can be found to provide these services, inquiries can be sent directly to the resource libraries at the addresses given. Any requests that can't be filled at the state level are eligible for referral to resource libraries in the Greater Midwest Regional Medical Library Network, which encompasses a ten-state area and to the National Library of Medicine.

In addition to providing lending and photocopying services, the two resource libraries and many of the local libraries provide reference service. Computer searches, including MEDLINE, can now be done at the resource libraries and at Winnebago Mental Health Institute, Winnebago; St Clare Hospital, Monroe; Ashland Memorial, Ashland; St Joseph's School of Nursing, Marshfield; Sheboygan Memorial, St Nicholas Hospital, Sheboygan; St Francis Medical Center, La Crosse; Sacred Heart Rehabilitation Center, Milwaukee; St Clare, Baraboo; St Croix Memorial Hospital, St Croix Falls; Beloit Memorial, Beloit; New Berlin Memorial, New Berlin; Columbia, St Joseph's, St Luke's, St Mary's, St Michael, St Francis hospitals and Sinai-Samaritan Medical Center, Milwaukee; Milwaukee County Medical Complex; Trinity Memorial Hospital, Cudahy; VA Hospital, Wood; St Elizabeth's Hospital, Appleton; Luther Hospital, Eau Claire; La Crosse Lutheran Hospital, La Crosse; Marshfield Clinic, Marshfield; Bellin Memorial Hospital, Green Bay; Waukesha Memorial Hospital, Waukesha; the Howard Young Medical Center, Woodruff; Holy Family Hospital, Manitowoc; Theda Clark Regional Medical Center, Neenah; Mercy Medical Center, Oshkosh; St Vincent's Hospital, Green Bay; Community Memorial Hospital, Menomonee Falls; Memorial Hospital at Oconomowoc, Oconomowoc; St Luke's Hospital, Racine; VA Hospital, Tomah; Wausau Hospital Center, Wausau; West Allis Memorial Hospital, West Allis; Mercy Hospital, Janesville; St Agnes Hospital, Fond du Lac; and Meriter-Methodist and Meriter-Madison General, Madison, St Marys Hospital Medical Center, VA Hospital, and UW Clinical Sciences Center in Madison. If your local library cannot provide computer searches, it can forward any request to the most appropriate library in the network. In most cases, the only charges will be for computer searches and for photocopies.

There are now software programs and training courses that assist health professionals do their own searching. Contact your local library or a resource library for information.

University of Wisconsin
Middleton Health Sciences Library
1305 Linden Drive
Madison, Wis 53706
800-362-3020, ext 2-2376

Medical College of Wisconsin
Todd Wehr Library
8701 Watertown Plank Rd
Milwaukee, Wis 53226
414-257-8326■

Physician guidelines: drawing blood for law enforcement

There are many circumstances under which law enforcement officers may desire analysis of a blood specimen(s) to determine the presence or concentration of a chemical substance(s) in a person's body. This situation is most likely to occur when drivers are suspected of driving while under the influence of alcohol or other drugs and frequently occurs when the suspect has been injured or is otherwise incapable of providing a breath or other specimen for testing.

Since the drawing of blood is limited by the medical practice act, such withdrawal of blood must be performed by, or at the direction of, a physician. Numerous questions have been raised about the potential liability of physicians or persons withdrawing blood at their direction when responding to police requests for such blood tests.

Wisconsin's implied consent law, effective May 1, 1970, granted limited liability protection for persons drawing blood; however, there remained concerns about situations not specifically covered by the law and subsequent changes in the law.

The 1985 legislature enacted a law which gives physicians, their agents and their employers immunity for liability when drawing blood under these circumstances:

> "Wis Stat. 895.53 Liability exemption; tests for intoxication. (2) Any person withdrawing blood at the request of a traffic officer, law enforcement officer or conservation warden for the purpose of determining the presence or quantity of alcohol, controlled substances or both is immune from any civil or criminal liability for the act, except for civil liability for negligence in the performance of the act.
>
> "(3) Any employer of the person under sub (2) or any hospital where blood is withdrawn by that person has the same immunity from liability under sub (2)."

Neither the implied consent law nor the 1985 law give absolute immunity. Negligence in drawing blood is still a basis for liability.

In 1970, the State Medical Society published guidelines for physicians in responding to law enforcement requests that blood specimens be obtained. The State Medical Society presents these revised recommendations for the guidance of physicians with the new and broad liability protection now in effect.

Recommendations

1. Physicians are urged to cooperate with law enforcement personnel when they request or direct that a blood specimen be obtained. Refusal to obey such direction from one known to be a law enforcement officer may be a criminal violation if the physician has no reasonable excuse to refuse (Wis. Stat. 946.40).

2. The physician must make an independent medical decision whether the procedure is safe under the circumstances and can be done under medically acceptable conditions. Drawing blood under medically unacceptable conditions may constitute a basis for claiming negligence in performance of the test. Roadsides, vehicles or jail cells will not generally qualify as medically acceptable conditions.

3. Wisconsin statutes do not address the reasonableness of obtaining blood from a person who requires restraint to make this possible. The US Supreme Court (Schmerber *v* California) ruled that blood could be withdrawn from a person who refused the test and resisted its performance so long as "inappropriate force" was not used.

4. It is recommended that the physician performing or ordering the blood withdrawal attempt to obtain written consent of the person to be tested. Whether the subject consents to the test, the officer ordering the test should submit this request in writing.

5. Police agencies that may desire blood specimens for such chemical testing are urged to make prior arrangements with physicians or hospitals so that procedures can be agreed on to minimize the potential for misunderstanding when the test is needed.■

Living will law

Since October 1984 Wisconsin has had a living will law in effect. A copy of the living will form is on the facing page with a description of the law on the reverse side. These laws allow adult persons to prospectively indicate their wishes concerning treatment of a terminal condition. A living will is only effective where the patient is no longer capable of participating in treatment decisions and where the application of medical procedures would serve only to prolong imminent death. In executing a living will, persons would not be authorized to consent to withholding or withdrawing of medical procedures which administer nutritional support or fluid maintenance—this provision has proved to be the most controversial since the law's implementation. Declarants of living wills are responsible for notifying their attending physicians, and the attending physician is required to file an original signed living will within the declarant's medical record.■

"LIVING WILL" FORM

DOH 0060 (Rev. 5/86)
s. 154.03 (1), (2)

Effective Date
April 22, 1986

PLEASE BE SURE YOU READ AND UNDERSTAND THE INFORMATION ON THE BACK BEFORE COMPLETING DECLARATION

DECLARATION TO PHYSICIANS

Declaration made this _____ day of _____ (month), _____ (year).

1. I, _____, being of sound mind, wilfully and voluntarily state my desire that my dying may not be artificially prolonged if I have an incurable injury or illness certified to be a terminal condition by 2 physicians who have personally examined me, one of whom is my attending physician, and if the physicians have determined that my death is imminent, so that the application of life-sustaining procedures would serve only to prolong artificially the dying process. Under these circumstances, I direct that life-sustaining procedures be withheld or withdrawn and that I be permitted to die naturally, with only: a. The continuation of nutritional support and fluid maintenance; and b. The alleviation of pain by administering medication or other medical procedure.

2. If I am unable to give directions regarding the use of life-sustaining procedures, I intend that my family and physician honor this declaration as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences from this refusal.

3. If I have been diagnosed as pregnant and my physician knows of this diagnosis, this declaration has no effect during the course of my pregnancy.

4. This declaration takes effect immediately.

I understand this declaration and I am emotionally and mentally competent to make this declaration.

Signed _____

Address _____

I know the declarant personally and I believe him or her to be of sound mind. I am not related to the declarant by blood or marriage, and am not entitled to any portion of the declarant's estate under any will of the declarant. I am neither the declarant's attending physician, the attending nurse, the attending medical staff nor an employe of the attending physician or of the inpatient health care facility in which the declarant may be a patient and I have no claim against the declarant's estate at this time, except that, if I am not a health care provider who is involved in the medical care of the declarant, I may be an employe of the inpatient health care facility regardless of whether or not the facility may have a claim against the estate of the declarant.

Witness _____

Witness _____

This declaration is executed as provided in chapter 154, Wisconsin Statutes.

Note: This blank form may be duplicated.

A. Definitions.

(1) "Attending physician" means a physician licensed under ch. 448 who has primary responsibility for the treatment and care of the patien

(2) "Declaration" means a written, witnessed document voluntarily executed by the declarant under chapter 154, Wisconsin Statutes, but not limited in form or substance to that provided in ch. 154. *Only the original declaration is a valid instrument.*

(3) "Health care professional" means a person licensed, certified or registered under ch. 441, 448 or 455.

(4) "Inpatient health care facility" has the meaning provided under s. 140.86 (1) and includes community-based residential facilities, a defined in s. 50.01 (1).

(5) "Life-sustaining procedure" means any medical procedure or intervention that, in the judgment of the attending physician, would serv only to prolong the dying process but not avert death when applied to a qualified patient. "Life-sustaining procedure" includes assistance i respiration, artificial maintenance of blood pressure and heart rate, blood transfusion, kidney dialysis and other similar procedures, but doe *not* include:

(a) The alleviation of pain by administering medication or by performing any medical procedure.

(b) The provision of fluid maintenance and nutritional support.

(6) "Qualified patient" means a declarant who has been diagnosed and certified in writing to be afflicted with a terminal condition by physicians, one of whom is the attending physician, who have personally examined the declarant.

(7) "Terminal condition" means an incurable condition caused by injury or illness that reasonable medical judgment finds would caus death imminently, so that the application of life-sustaining procedures serves only to postpone the moment of death.

B. Who May Sign A Declaration

Any person 18 years of age or older and of sound mind may voluntarily execute a declaration authorizing the withholding or withdrawal c life-sustaining procedures when the person is in a terminal condition.

C. Effective Date

This declaration takes effect immediately.

D. Procedures For Signing Declarations

A declaration must be signed by the declarant in the presence of 2 witnesses.

If the declarant is physically unable to sign the declaration, the declaration must be signed in the declarant's name by one of the witnesses o some other person at the declarant's express direction and in his or her presence. Such a proxy signing shall either take place or b acknowledged by the declarant in the presence of 2 witnesses.

The declarant is responsible for notifying his or her attending physician of the existence of the declaration. An attending physician who is s notified shall make the original declaration a part of the declarant's medical records.

E. Restrictions on Witnesses

Witnesses to the signing of a declaration may *not*:

1) Be related to the declarant by blood or marriage.
2) Be entitled to any portion of the estate of the declarant upon his or her decease under any will of the declarant.
3) Be the attending physician, the attending nurse or the attending medical staff, an employe of the attending physician or an employe of th inpatient health care facility in which the declarant is a patient who is a health care provider under s. 146.81 (1) and is involved in th medical care of that patient, or have a claim against any portion of the estate of the declarant upon his or her death at the time of th execution of the declaration.

F. Revocation of Declaration

A declaration may be revoked at any time by the declarant by any of the following methods:

1) By being canceled, defaced, obliterated, burned, torn or otherwise destroyed by the declarant or by some person who is directed by th declarant and who acts in the presence of the declarant.
2) By a written revocation of the declarant expressing the intent to revoke, signed and dated by the declarant.
3) By a verbal expression by the declarant of his or her intent to revoke the declaration, but only if the declarant or a person acting on behal of the declarant notifies the attending physician of the revocation.

The attending physician shall record in the declarant's medical records the time, date and place of the revocation and time, date and place, i different, that he or she was notified of the revocation.

G. Effect of Declaration

The desires of a qualified patient who is competent supersede the effect of the declaration at all times. If a qualified patient is incompetent a the time of the decision to withhold or withdraw life-sustaining procedures, a declaration, properly executed, is presumed to be valid.

The declaration of a qualified patient who is diagnosed as pregnant by the attending physician has no effect during the course of the pregnancy.

In the absence of actual notice to the contrary, a physician or inpatient health care facility may presume that a person who executed a declaration was of sound mind at the time.

H. Liabilities

No physician, inpatient health care facility or health care professional acting under the direction of a physician may be held criminally o civilly liable, or charged with unprofessional conduct, for any of the following:

1) Participating in the withholding or withdrawal of life-sustaining procedures under ch. 154.
2) Failing to act upon a revocation unless the person or facility has actual knowledge of the revocation.
3) Failing to comply with a declaration, except that failure by a physician to comply with a declaration of a qualified patient constitutes unprofessional conduct if the physician refuses or fails to make a good faith attempt to transfer the patient to another physician who will comply with the declaration.

I. General Provisions

SUICIDE. The withholding or withdrawal of life-sustaining procedures in accordance with Ch. 154 does not, for any purpose, constitute suicide. Execution of a declaration does not, for any purpose, constitute attempted suicide.

LIFE INSURANCE. Execution of a declaration under Ch. 154 may not be used to impair in any manner the procurement of any policy of life insurance. No policy of life insurance may be impaired in any manner by the withholding or withdrawal of life-sustaining procedures from an insured qualified patient.

HEALTH INSURANCE. No person may be required to execute a declaration as a condition prior to being insured for, or receiving, health care services.

Division of Health, P.O. Box 309, Madison, WI 53701

MEDICAL ETHICS

CURRENT OPINIONS OF THE JUDICIAL COUNCIL OF THE American Medical Association, 1986. This new edition, originally compiled in 1958 and revised annually, is intended as an adjunct to the revised Principles of Medical Ethics that were adopted at the AMA Annual Convention in 1980. The opinions are intended as guides to responsible professional behavior, but they are not presented as the sole or only route to medical morality. Behavior relating to medical etiquette, custom or usage is not included.

The following topics are included in the booklet:

- **Opinions on Social Policy Issues**
  - Abortion
  - Abuse of Children, Elderly Persons, and Others at Risk
  - Allocation of Health Resources
  - Artificial Insemination
  - Artificial Insemination by Donor
  - Capital Punishment
  - Clinical Investigation
  - Costs
  - Fetal Research Guidelines
  - Genetic Counseling
  - Genetic Engineering
  - In Vitro Fertilization
  - Organ Transplantation Guidelines
  - Quality of Life
  - Terminal Illness
  - Treatment of patients seropositive for or diagnosed with AIDS
  - Unnecessary Services
- **Opinions on Confidentiality, Advertising and Communications Media Relations**
  - Advertising and Publicity
  - Advertising and HMOs
  - Communications Media: Press Relations
  - Communications Media: Standards of Professional Responsibility
  - Confidentiality
  - Confidentiality: Attorney-Physician Relation
  - Confidentiality: Computers
  - Confidentiality: Insurance Company Representative
- **Opinions on Practice Matters**
  - Appointment Charges
  - Clinics
  - Consultation
  - Contingent Physician Fees
  - Contractual Relationship
  - Drugs and Devices: Prescribing
  - Informed Consent
  - Laboratory Services
  - Lien Laws
  - Neglect of Patient
  - Patient Information
  - Substitution of Surgeon Without Patient's Knowledge or Consent
- **Opinions on Hospital Relations**
  - Admission Fee
  - Assessments, Compulsory
  - Billing for Housestaff Services
  - Health Facility Ownership by Physician
  - Organized Medical Staff
  - Physician-Hospital Contractual Relations
  - Staff Privileges
- **Opinions on Physician Records**
  - Records of Physicians: Availability of Information to Other Physicians
  - Records of Physicians: Information and Patients
  - Records of Physicians on Retirement
  - Sale of a Medical Practice
- **Opinions on Professional Rights and Responsibilities**
  - Accreditation
  - Agreements Restricting the Practice of Medicine
  - Civil Rights and Professional Responsibility
  - Discipline and Medicine
  - Due Process
  - Free Choice
  - Patent for Surgical or Diagnostic Instrument
  - Peer Review
- **Opinions on Interprofessional Relations**
  - Nonscientific Practitioners
  - Nurses
  - Optometry
  - Referral of Patients
  - Specialists
  - Sports Medicine
  - Teaching
- **Opinions on Fees and Charges**
  - Fees for Medical Services
  - Fees: Group Practice
  - Fee Splitting
  - Fee Splitting: Clinic or Laboratory Referrals
  - Fee Splitting: Drug Prescription Rebates
  - Insurance Form Completion Charge
  - Interest Charges and Finance Charges
  - Laboratory Bill
  - Surgical Assistant's Fee
  - Competition

The State Medical Society of Wisconsin Board of Directors has adopted the AMA Principles of Medical Ethics as the ethical guidelines of the Society. The Society may refer to the Judicial Council Opinions for further guidance.

Copies of the *Opinions* are available by direct order to: Current Opinions of the Council on Ethical and Judicial Affairs (OP-122), American Medical Association, PO Box 10946, Chicago, IL 60610 (the distribution location of AMA publications).

The price is $9.50 each for 1–9 copies; $5.40 each for 10–49 copies; and $4.80 each for 50 copies or more. Prices include charges for handling and shipping. Residents of Illinois and New York, please add appropriate state sales tax to total.■

UNPROFESSIONAL CONDUCT DEFINED

Med 10.01 Authority and purpose. The definitions of this chapter are adopted by the medical examining board pursuant to the authority delegated by ss. 15.08 (5), 227.08, and 448.40, Stats., for the purposes of ch. 448, Stats.

Med 10.02 Definitions. (1) For the purposes of these rules:

(a) "Board" means the medical examining board.

(b) "License" means any license, permit, certificate, or registration issued by the board.

(2) The term "unprofessional conduct" is defined to mean and include but not be limited to the following, or aiding or abetting the same:

(a) Violating or attempting to violate any provision or term of chapter 448 of the statutes or of any valid rule of the board.

(b) Violating or attempting to violate any term, provision, or condition of any order of the board.

(c) Knowingly making or presenting or causing to be made or presented any false, fraudulent, or forged statement, writing, certificate, diploma, or other thing in connection with any application for license.

(d) Practicing fraud, forgery, deception, collusion, or conspiracy in connection with any examination for license.

(e) Giving, selling, buying, bartering, or attempting to give, sell, buy, or barter any license.

(f) Engaging or attempting to engage in practice under any license under any given name or surname other than that under which originally licensed or registered to practice in this or any other state. This subsection does not apply to change of name resulting from marriage, divorce, or order by a court of record.

(g) Engaging or attempting to engage in the unlawful practice of medicine and surgery or treating the sick.

(h) Any practice or conduct which tends to constitute a danger to the health, welfare, or safety of patient or public.

(i) Practicing or attempting to practice under any license when unable to do so with reasonable skill and safety to patients.

(j) Practicing or attempting to practice under any license beyond the scope of that license.

(k) Offering, undertaking, or agreeing to treat or cure a disease or condition by a secret means, method, device, or instrumentality; or refusing to divulge to the board upon demand the means, method, device, or instrumentality used in the treatment of a disease or condition.

(l) Representing that a manifestly incurable disease or condition can be or will be permanently cured; or that a curable disease or condition can be cured within a stated time, if such is not the fact.

(m) Knowingly making any false statement, written or oral, in practicing under any license, with fraudulent intent; or obtaining or attempting to obtain any professional fee or compensation of any form by fraud or deceit.

(n) Wilfully divulging a privileged communication or confidence entrusted by a patient or deficiencies in the character of patients observed in the course of professional attendance, unless lawfully required to do so.

(o) Engaging in uninvited, in-person solicitation of actual or potential patients who, because of their particular circumstances, are vulnerable to undue influence; or engaging in false, misleading or deceptive advertising.

(p) Administering, dispensing, prescribing, supplying, or obtaining controlled substances as defined in s. 161.01 (4), Stats. otherwise than in the course of legitimate professional practice, or as otherwise prohibited by law.

(q) Having a license, certificate, permit, or registration granted by another state to practice medicine and surgery or treat the sick limited, restricted, suspended, or revoked, or having been subject to other disciplinary action by the licensing authority thereof.

(r) Conviction of any crime which may relate to practice under any license, or of violation of any federal or state law regulating the possession, distribution, or use of controlled substances as defined in s. 161.01 (4), Stats. A certified copy of a judgment of a court of record showing such conviction, within this state or without, shall be presumptive evidence thereof.

(s) Prescribing, ordering, dispensing, administering, supplying, selling, or giving any amphetamine, sympathomimetic amine drug or compound designated as a schedule II controlled substance pursuant to the provisions of ch. 161 Stats. to or for any person except for the treatment of narcolepsy, or for the treatment of hyperkinesis, or for the treatment of drug induced brain dysfunction, or for the treatment of epilepsy, or for the differential diagnostic psychiatric evaluation of depression, or for the treatment of depression shown to be refractory to other therapeutic modalities, or for the clinical investigation of the effects of such drugs or compounds in which case an investigative protocol therefore shall have been submitted to and reviewed and approved by the board before such investigation has been begun.

(t) Aiding or abetting the unlicensed practice of medicine or representing that unlicensed persons practicing under supervision, including unlicensed M.D.'s and D.O.'s, are licensed, by failing to identify the individuals clearly as unlicensed physicians or delegates.

(u) Failure to inform a patient about the availability of all alternate, viable medical modes of treatment and about the benefits and risks of these treatments, including the benefits and risks associated with the use of extended wear contact lenses. ■

STATE GOVERNMENT AGENCIES

AS OF MAY 15, 1988

CONSTITUTIONAL OFFICERS

GOVERNOR
Tommy Thompson 266-1212

LIEUTENANT GOVERNOR
Scott McCallum 266-3516

SECRETARY OF STATE
Douglas LaFollette 266-5801

TREASURER
Charles P. Smith 266-3711

ATTORNEY GENERAL
Donald Hanaway 266-1221

SUPERINTENDENT OF PUBLIC INSTRUCTION
Herbert Grover 266-3390

Department of Health and Social Services

1 W Wilson St, Madison, Wis 53702 • Tel 608/266-3681

EXECUTIVE STAFF

SECRETARY
Timothy Cullen 266-3681

DEPUTY SECRETARY
Jeff Kunz, MD 266-3681

DIVISION ADMINISTRATORS

Alan Fish 266-8402
Policy and Budget

Patricia Goodrich 266-3173
Management Services

Stephen Bablitch 266-2471
Corrections

Linda Belton 266-8740
Care and Treatment Facilities

John Torphy 266-1511
Health

James Meier 266-2701
Community Services

Judy Norman-Nunnery 266-1281
Vocational Rehabilitation

DIVISION OF HEALTH

1 W Wilson St; Room 234
PO Box 309
Madison, Wis 53701
Tel 608/266-1511
Note: Use box number on First Class Mail for all bureaus.

ADMINISTRATOR
John Torphy

ASSISTANT ADMINISTRATOR for Public Health Services
William Schmidt

ASSISTANT ADMINISTRATOR for Health Administration
John Chapin

BUREAUS

Management & Policy 266-7384
- Staffing of Health Policy Council
- Development of State Health Plan
- Graduate Medical Education
- Administration of Resource Allocation Program (nursing home projects)
- Health Personnel Shortage Areas Recruitment

Health Care Financing 266-2522
- Administration of the Medical Assistance Program
- EPSDT—Early and periodic screening, diagnosis and treatment for children and other screening activities

Quality Compliance 266-8847
- Title 18 and Title 19 certification
- Hospital and nursing home standard setting and enforcement
- Patient care evaluation
- Construction and plan review
- Development of facilities standards

Community Health & Prevention 266-1251
- Development and promotion of prevention programs
- Standard epidemiology
- Environmental epidemiology
- Immunization activities
- Communicable diseases
- Chronic diseases
- Participation in preventive efforts within and outside the Department of Health and Social Services
- Promotion of research into major causes of illness and death and sponsorship of demonstration projects designed to reduce and eliminate root causes
- Laboratory certification
- Public health nursing
- Public health nutrition
- Dental health
- Maternal and child health
- Family planning

Correctional Health Services 266-5718
- Assurance of sufficient levels of physical health care for all inmates in correctional institutions and at Central State Hospital
- Management of the provision of such services to insure effectiveness and efficiency
- Recruitment and staffing of health care positions in the correctional institutions

Environmental Health 266-9377
(1400 E Washington Ave, Madison 53702)
- Certification of Grade A milk
- Inspection of hotels, restaurants and food vending services where not performed by local public health agencies
- General environmental sanitation
- Recreational inspection
- Radiation protection
- Occupational health services
- Development of emergency medical services systems

Health Statistics 266-1939
- Vital Statistics
- Resource data
- Demographic and special analysis
- Services data

REGIONAL OFFICES

MADISON 53704-1104
3518 Memorial Dr, Bldg 4
Tel 608/249-8928
Long Term Care, 608/273-6340
5708 Odana Rd, 53719

MILWAUKEE 53203
819 North 6th St, Rm 860
Tel 414/224-3033
Long Term Care, 414/227-5000

GREEN BAY 54301-5158
200 N Jefferson, Ste 211
Tel 414/436-5968
Long Term Care, 414/436-3074

EAU CLAIRE 54701-6143
Eau Claire State Office Bldg
718 W Clairemont Ave
Tel 715/836-3843
Long Term Care, 715/836-4752

RHINELANDER 54501-1165
1853 N Stevens St
PO Box 1165
Tel 715/362-7800

Note: Use box numbers on First Class Mail

continued next page

DIVISION OF COMMUNITY SERVICES

State Office: 1 W Wilson St
PO Box 7851
Madison, Wis 53707
Tel: 608/266-2701

ADMINISTRATOR'S OFFICE

Administrator 266-0554
Eloise Anderson

Deputy Administrator 267-9059
Linda Dupont-Johnson

Assistant Administrator 266-9879
Gerald Born

Assistant to the Administrator and Deputy Administrator . . . 267-7181
Larry Reuter

Legislative Liaison
Vacant

Public Information 266-1138
Peggy Schmitt

BUREAUS

Aging 266-3840
Donna McDowell

Children, Youth & Families . . 266-6946
Vacant

Community Programs 266-3719
Phil McCullough, Director

- Alcohol & Other Drug Abuse 266-3442
  Larry Monson
- Developmental Disabilities . . 266-9329
  Dennis Harkins
- Mental Health 266-3249
  Debbie Allness
- Physically Impaired 266-9582
  Dan Johnson
- Program Support 266-2862
  Kary Hyre

Economic Assistance 266-3035

- Planning & Implementation 266-2850
  Mary Ann Cook
- Program Compliance 266-1080
  Joe Stafford

Long-Term Support 266-9304
Tom Hamilton

Management and Budget 266-3782
Mark Hoover, Director

- Budget & Aids Section 266-3728
  Bill Fiss
- Financial Management 267-3606
  Peter Gehrke
- Indian Affairs 266-5862
  Nancie Young
- Operations & Support 266-9674
  David Robertson
- Hispanic / Migrants 267-9202
  Irma Guerra
- Wisconsin Resettlement Asst 266-8358
  Jules Bader

Social Security Disability Insurance 266-8358
William Griffin, Director
722 Williamson St, PO Box 7886
Madison WI 53703

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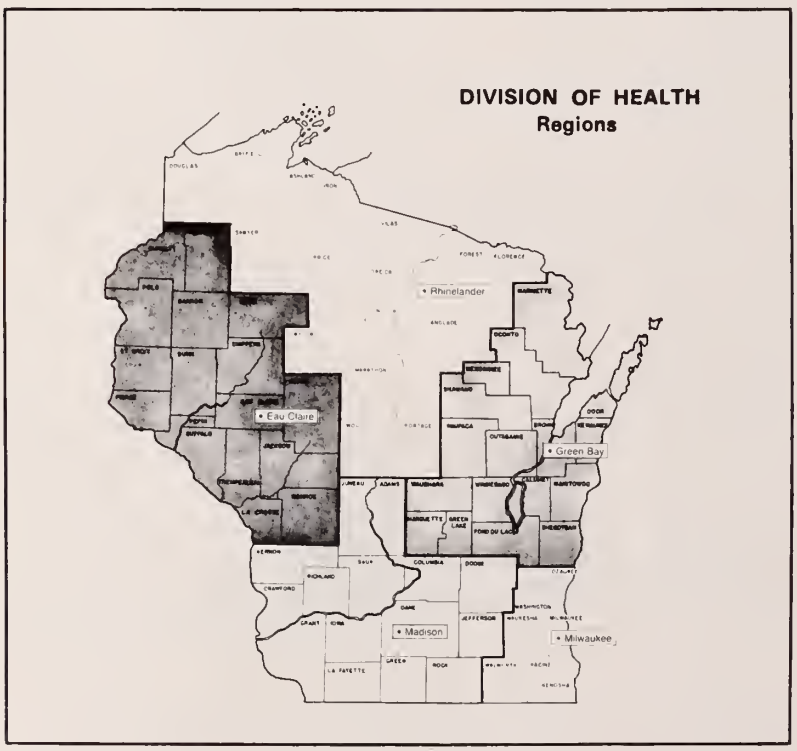

Controlled Substances Board 266-7586

June L Dahl, PhD, Chairman, Professor of Pharmacology, University of Wisconsin–Madison

David P Donarski, MD, Green Bay

John W Killian, Director, Bureau of Narcotics and Vice (Representing the Attorney General)

Mike Boushon, Pharmacy Practices Consultant DHSS (Representing the Department of Health and Social Services)

D Jack Myers, RPh (Representing the Pharmacy Examining Board)

Gerald R Myrdal, Bureau of Lab Services (Representing the Department of Agriculture, Trade and Consumer Protection)

* * *

STAFF: David E Joranson, Controlled Substances Policy Specialist (ph 608 / 266-7586), and *Amy Bachmann, RPh,* Staff Assistant (ph 608/ 267-2399), Controlled Substances Board, Bureau of Community Programs, Department of Health and Social Services, 1 West Wilson St, PO Box 7851, Madison, Wis 53707

Center for Health Statistics Division of Health

The Center is the custodian of birth, death, marriage, and divorce records for the State (ss. Chapter 69). Also, the Center has a contract with the National Center for Health Statistics for collection of vital statistics and partial funding from the Health Care Financing Administration for the collection and analysis of data on hospital discharge and health facilities. Several other activities are being carried out in areas such as cancer reporting, blood alcohol reporting, public health service data, and sample ambulatory medical care and household interview health status data. Another of the Center's activities is the production of annual population estimates for Wisconsin counties, a part of the Federal-State Cooperative Program of the Bureau of the Census. Inquiries may be made to: R D Nashold, Director, Center for Health Statistics, PO Box 309, Madison, WI 53701.

DIVISON OF COMMUNITY SERVICES
continued

OFFICES

Child Support.....266-1175
Ada Skyles, Director
Management Information....266-7936
Lowell Trewartha, Director

REGIONAL OFFICES

WESTERN
Marjorie Kelly, Director
Box 228, 718 West Clairmont Ave,
Eau Claire 54702
Tel 715/836-2157

EASTERN
Lewis McCauley, Director
200 North Jefferson #411
Green Bay 54301
Tel 414/436-3043

SOUTHERN
Mary Southwick, Director
3601 Memorial Dr, Madison 53704
Tel 608/249-0441

MILWAUKEE
Silvia R Jackson, Director
819 N 6th St, Milwaukee 53203
Tel 414/227-4563

SOUTHEASTERN
Chuck Holton, Director
141 NW Barstow, PO Box 1258
Waukesha 53187
Tel 414/521-5098

NORTHERN
Barbara Voltz, Director
1853 North Stevens St, PO Box 697
Rhinelander 54501
Tel 715/362-7800

DISTRICT OFFICES

FOND DU LAC 54935
485 South Military Road, Box 1069
Tel 414/929-2985

ASHLAND 54806
601 2nd St, West, Box 72
Tel 715/682-3405

WISCONSIN RAPIDS 54494
1681 Second Ave, South, Box 636
Tel 715/423-4305

LaCROSSE 54601
3550 Mormon Coulee Road, Box 743
Tel 608/785-9453

* * *

DIVISION OF VOCATIONAL REHABILITATION

State Office: 1 W Wilson, Rm 850
POB 7852, Madison, Wis 53707
Tel: 608/266-1281

Administrator.....266-5466
J R Norman-Nunnery
Deputy Administrator.....266-2168
Kenneth T McClarnon

BUREAUS

Client Services

John H Biddick, Regional
Administrator.....266-1283
Olaf Brekke, Regional
Administrator.....266-2380
R F Truesdell, Regional
Administrator.....266-0589
R R VanDeventer, Regional
Administrator.....266-0605

Operations and Planning

Patrick Mommaerts,
Director.....266-2956
Robert Cohen, Assistant
Bureau Director.....267-5222
- Planning and Program Support
  Suzanne Lee 267-8338
  Susan Kidder 267-7364

Sensory Disabilities

Ken McClarnon,
Acting Director 266-2168
- Office for the Hearing Impaired
  Herb Pickell, Director.....266-7802
  Tom Sanew,
  CHIS Coordinator 266-8410
- Office for the Visually Impaired
  Michael Nelipovich,
  Acting Director.....266-5600

Governor's Committee for People with Disabilities

Ellen Daly, Director 266-5378

FIELD OFFICES

L E Opheim, Supervisor
517 Walker Ave
Eau Claire 54701
Tel 715/836-4263

Paul Monzel, Supervisor
820 S Main St
POB 1438
Fond du Lac 54935
Tel 414/921-5883

John Haugh, Supervisor
200 N Jefferson St
Green Bay 54301
Tel 414/497-3417

Wayne Olson, Supervisor
514 South Main St
Janesville 53545
Tel 608/755-2780

Willie Riley, Supervisor
712-55th St
Kenosha 53140
Tel 414/656-6453

Michael Gilbert, Supervisor
333 Buchner Pl
La Crosse 54601
Tel 608/785-9500

Vacant, Supervisor
600 Williamson St, Suite F
Madison 53703
608/266-3655

Manuel Lugo, Supervisor
5005 University Ave, Suite 2
Madison 53705
608/266-4541

William R Newberry, Supervisor
120 E Capitol Dr
Milwaukee 53212
Tel 414/963-2440

Noreen Ryan, Supervisor
6815 W Capital Dr
Milwaukee 53216
Tel 414/438-4881

Al DeBow, Supervisor
3501 S Howell St
Milwaukee 53207
Tel 414/769-2600

Jeanne Leland, Supervisor
9401 W Beloit Rd, Rm 408
Milwaukee 53227
Tel 414/546-8340

James Mather, Supervisor
303 Pearl Ave
Oshkosh 54901
Tel 414/424-2028

Vacant, Supervisor
311 E Wisconsin
Portage 53901
Tel 608/742-8594

Sharlene Hatcher, Supervisor
5200 Washington Ave
Racine 53406
Tel 414/636-3388

Roger Tooke, Supervisor
158 S Anderson St
Rhinelander 54501
Tel 715/369-3930

Michael Schroeder, Supervisor
11 E Eau Claire
Rice Lake 54868
Tel 715/234-6806

George Herrmann, Supervisor
1428 N 5th
Sheboygan 53081
Tel 414/459-3883

Leroy Forslund, Supervisor
917 Tower Ave
Superior 54880
Tel 715/392-8171

Frank Broder, Supervisor
141 NW Barstow
Waukesha 53187
Tel 414/548-5850

Kenneth Crass, Supervisor
2416 Stewart Sq
Wausau 54401
Tel 715/845-9261

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Dan Eisch, Supervisor
1810-9th St, S
Wisconsin Rapids 54494
Tel 715/424-1100

* * *

DIVISION OF CARE AND TREATMENT FACILITIES

State Office: 1 W Wilson St
PO Box 7851
Madison, Wis 53707
Tel: 608/266-8740

Administrator.....266-8740
Linda W Belton
Deputy Administrator.....267-7921
Gerald E Dymond
Program Support.....267-2254
Donald Pahnke
Planning and Evaluation 266-5774
Beth Cox
Forensics Services 266-1856
Marvin Chapman, MD
Client Advocacy 266-2713
Joy Schwert/Shary Bisgard
Affirmative Action/Civil Rights Compliance.....266-3993
Georgina Taylor
Central WI Center for the Developmentally Disabled ...249-2151
R C Scheerenberger, PhD
Northern WI Center for the Developmentally Disabled.....715/723-5542
Terry Willkom
Southern WI Center for the Developmentally Disabled.....414/878-2411
Michael J Moore
Mendota Mental Health Institute.....244-2411
Terry Schnapp
Winnebago Mental Health Institute 414/235-4910
H David Goers
Wisconsin Resource Center.....414/426-4310
Phillip Macht■

Department of Regulation and Licensing

1400 E Washington Ave
PO Box 8935
Madison, Wis 53708
Tel 608/266-2112

Marlene A Cummings, Secretary.....266-8609
Joyce D Waldrop, Deputy Secretary
Don Severson, Executive Assistant

BUREAU OF HEALTH PROFESSIONS (Partial listing)

John M Young, Madison.....266-0483
Bureau Director

Medical Examining Board

Gwen Jackson (1988), Milwaukee
Chairman (Public Member)
Michael Mehr, MD (1991), Marshfield, Vice Chairman
G Thomas Pfaehler, MD (1989), Madison
Secretary
Douglas G Devan, MD (1989), Kenosha
George W Arndt Sr, MD (1991), Neenah
Arlen Delp, DO (1990), Muskego
Henry M Waldren Jr, MD (1990), West Allis
Susan Behrens, MD (1991), Beloit
Judy Crain (1988), Green Bay
(Public Member)
Vacancy (Patient's Compensation Fund)
Clark O Olsen, MD (1991), Ashland

* * *

Physical Therapist Examining Council
Council on Physician's Assistants
Podiatry Examining Council

* * *

Dentistry Examining Board

Kathleen Kelly, DDS (1989)....Madison
Chairman
David Crane, DDS (1989).....Cadott
Vice-chairman
Robert J Mork, DDS (1989)...Janesville
Secretary
Eva Dahl, DDS (1990) .....La Crosse
Diane Bergschneider, RDH (1988).....Milwaukee
Jeffrey Leavell (1990).....Racine
(Public Member)
Mary K Ryan (1988) .....Madison
(Public Member)
Robert A Henschel, DDS (1991).....Elm Grove

* * *

Pharmacy Examining Board

Kenneth Schaefer, RPh (1991), Mosinee
Rod C Bohn, RPh (1989), Sturgeon Bay
Chair
Charles W Lang, Jr, RPh (1989), Viroqua
Secretary
Pamela A Ploetz, RPh (1990), Madison
D Jack Myers, RPh (1988), Madison
Vice Chair
Victor C McHenry (Public Member) (1990), Milwaukee
Joan G Hedden (Public Member) (1988), Racine

STAFF
John M Young, Madison
Bureau Director.....266-0483
Roberta Ward, Madison
Program Assistant.....266-8794

BUREAU OF HEALTH SERVICE PROFESSIONS (Partial listing)

Ramona Weakland Warden, Madison
Director.....267-7223

Board of Nursing

Mary Ann Clark, RN (1990)
Chair.....Cumberland
Evelyn Maloney, LPN (1990).....Chippewa Falls
Jacqueline Johnsrud, RN (1991).....Eastman
Rosella Van Hollen, RN (1991) .....Mason
Jane Travis, RN (1988)
Vice Chair .....Onalaska
John Bartkowski, RN (1990).....Milwaukee
Janice Kerley, LPN (1989)
Secretary .....Milwaukee
Ellen Ryan (1987)
(Public Member) .....Madison
Shirley Webb (1989)
(Public Member).....Chetek■

Department of Industry, Labor & Human Relations

PO Box 7946, 201 E Washington Ave
Madison, Wis 53707
Tel 608/266-7552

Secretary's Office
John T Coughlin, *Secretary*..Madison
Michael F Corry
Deputy Secretary.....Madison
Ray Allen
Executive Assistant.....Madison

Division Administrators
Unemployment Compensation ..266-7074
Donald Stone
Employment & Training Policy.266-2439
June Suhling
Worker's Compensation.....266-6841
Christ M Faulhaber, Jr
Job Service 266-8561
Jim Johnson
Safety & Buildings.....266-1816
William Norem
Administration & Management..266-1024
Michael Lovejoy
Equal Rights.....266-0946
Myra Shelton■

Office of the Commissioner of Insurance

PO Box 7873, Madison, WI 53707

Robert Haase 266-0102
Commissioner
Mary Alice Coan 267-2833
Attorney (PCF)
Robert Elconin 266-0081
Deputy Commissioner
Marvin Van Cleave 266-8537
Assistant Deputy Commissioner

Legal Unit
Fred Nepple 266-7726
Attorney Supervisor
Bob Luck 266-0082
Attorney

REGULATION & ENFORCEMENT DIVISION
Greg Krohn 266-9892
Administrator

DIVISION OF ADMINISTRATIVE SERVICES
Hilde Neujahr 266-5673
Administrator

PATIENTS COMPENSATION FUND
Danford Bubolz 266-0953
Administrative Assistant■

Office of State Courts

PO Box 1688
Madison 53701-1688

J Denis Moran 266-6828
Director of State Courts■

Medical Mediation Panels

110 E Main St, Rm 210
Madison 53703

Randy Sproule 266-7711
Director■

OCI
OFFICE OF THE COMMISSIONER OF INSURANCE

P.O. Box 7873
Madison, Wisconsin 53707-7873

CONSUMER PUBLICATIONS

Individual copies may be obtained by sending a self-addressed envelope to the above address. Check those you would like to receive. Multiple copies are available at the listed price.

Pay in advance by check or money order payable to Commissioner of Insurance.

ALL MATERIALS MAY BE COPIED WITHOUT PERMISSION.

NC = No charge first 10 copies - .05 each after 10

HEALTH

____ Health Insurance Advice for Senior Citizens (.20) (PI-2) (Limit - 25) ($.10 for up to 25 copies picked up at the office)

____ List of Approved Medicare Supplement Policies (NC) (PI-10)

____ Health Insurance - A Primer (NC) (PI-42)

____ Buyer's Guide to Health & Disability Income Insurance (.05) (PI-5)

____ Fact Sheet on Mandated Benefits for Treatment of Alcoholism, Drug Abuse, Mental & Nervous Disorders (.05) (PI-8)

____ Mandated Benefits for the Treatment of Nervous And Mental Disorders, Alcoholism & Other Drug Abuse (NC) (PI-39)

____ Fact Sheet on Mandated Benefits in Health Insurance Policies (.05) (PI-19)

____ Information Sheet on Cancer Insurance (NC) (PI-1)

____ Fact Sheet on Nursing Home Insurance (NC) (PI-12)

____ Fact Sheet on Pregnancy, Employment & the Law (NC) (PI-18)

____ Health Care Insurance in Wisconsin (NC) (PI-20)

List of Licensed HMO's
____ By County (NC) (PI-27A)
____ Alphabetical (NC) (PI-27B)

____ HMO's - Number of Enrollees (NC) (PI-28)

____ Consumer Guide to HMO's (NC) (PI-41)

Health Insurance Continuation & Conversion
____ For Employers (NC) (PI-22)
____ For Consumers (NC) (PI-23)

____ Wisconsin Health Insurance Risk-Sharing Plan (Free)

____ Fact Sheet on Continuing Care Contracts (NC) (PI-34)

____ Continuing Care Facilities (NC) (PI-35)

Accident & Health Complaint Summaries
____ Individual (NC) (PI-32)
____ Group (NC) (PI-33)

Charging for medical reports

In recent months the Wisconsin Division of Industry, Labor and Human Relations has received inquiries on its position regarding reimbursement to the medical providers; especially physicians and chiropractors, for preparing and filing requested reports. The position of the division has not changed over the years as it applies to the following:

- Initial, interim and final reports. No additional charge.
- WC-16B Reports. No additional charge.
- However, when special detailed reports requiring time or research are required by the regulations, the insurance carrier, the injured employee or their counsel, a reasonable charge for their preparation and filing is appropriate.

If you are in doubt about charging for medical reports or the reimbursement of them, please feel free to contact the Worker's Compensation Division, 201 E Washington Ave, Room 161, Madison, WI 53707 or call 608-266-1340.

Remember, if all parties involved with a claim cooperate, the likelihood of litigation can be avoided, the total cost of the claim can be reduced, and the injured employee will be able to return to the work force sooner.■

Induced abortions must be reported

The Center for Health Statistics in the State Division of Health is responsible for implementing state statute 69.186 which requires hospitals, clinics, or other facilities to report induced abortions to the State Department of Health and Social Services, according to Raymond D Nashold, PhD, State Registrar and Director of the Center.

The Wisconsin Induced Abortion Reporting System initiated collection of data with the beginning of calendar year 1987. The statute follows:

Induced Abortion Reporting (s. 69.186)

(1) On or before January 15 annually, each hospital, clinic or other facility in which an induced abortion is performed shall file with the department a report for each induced abortion performed in the hospital, clinic or other facility in the previous calendar year. Each report shall contain all of the following information with respect to each patient obtaining an induced abortion in the hospital, clinic or other facility:

(a) The state and, if this state, the county, of residence.
(b) Patient number.
(c) Race.
(d) Age.
(e) Marital status.
(f) Month and year in which the induced abortion was performed.
(g) Education.
(h) The number of weeks since the patient's last menstrual period.
(i) Complications, if any, resulting from performance of the induced abortion.

(2) The department shall collect the information under sub. (1) in a manner which the department shall specify and which ensures the anonymity of a patient who receives an induced abortion, a health care provider who provides an induced abortion and a hospital, clinic or other facility in which an induced abortion is performed. The department shall publish annual demographic summaries of the information obtained under this section, except that the department may not disclose any information obtained under this section that reveals the identity of any patient, health care provider or hospital, clinic or other facility and shall ensure anonymity in all of the following ways:

(a) The department may use information concerning the patient number under sub. (1) (b) or concerning the identity of a specific reporting hospital, clinic or other facility for purposes of information collection only and may not reproduce or extrapolate this information for any purpose.

(b) The department shall immediately destroy all reports submitted under sub. (1) after information is extrapolated from the reports for use in publishing the annual demographic summary under this subsection.

In section 69.186, the term "induced abortion" means:

> the termination of a uterine pregnancy by a physician of a woman known by the physician to be pregnant, for a purpose other than to produce a live birth or to remove a dead fetus.

Enacted April 29, 1986.

— — —

Reprinted from *Wisconsin Medical Journal*, December 1986.■

HELP IS AVAILABLE

to your patients when they ask you about nursing homes, long-term care services, or health insurance to supplement Medicare

Call 1-800-242-1060

The following services are provided by the State of Wisconsin, Board on Aging and Long Term Care:

Ombudsman Program

Purpose:

- The ombudsman program was established by the state legislature to investigate complaints from any person concerning improper treatment of aged or disabled persons receiving long-term care in Wisconsin.
- The ombudsman will serve as an objective investigator, mediator, or advocate with a goal to resolve any problem or dispute relating to long-term care.
- The ombudsmen provide presentations on nursing home residents' rights and other topics related to long-term care.
- The ombudsmen answer questions concerning a wide range of issues, ranging from public benefits to nursing home care.

Questions commonly asked are:

—What are my rights and responsibilities as a resident of a long-term care facility?

—How can I finance long-term care?

—Is guardianship different from power of attorney or conservator?

—What are the alternatives to a nursing home?

—What recourse do I have if friends or relatives are mistreated in a long-term care facility?

Medigap Hotline

The Medigap hotline provides information and counseling to Wisconsin residents on health insurance in addition to Medicare, i.e., Medicare supplement insurance, hospital indemnity, cancer and nursing home insur-

WISCONSIN ADOPTION AGENCIES

Licensed adoption service agencies

Adoption Advocates, Inc.
1310 Mendota Street
Madison, WI 53714
(608) 246-2844

Adoption Choice
2542 North Terrace Avenue
Milwaukee, WI 53211
(414) 332-7732

Adoption Option
1804 Chapman Drive
Waukesha, WI 53186
(414) 544-4278

Adoption Services of Green Bay
130 East Walnut Street
Green Bay, WI 54301
(414) 433-9071

Bethany Christian Services of Wisconsin
W255 N477 Grandview Boulevard
Suite 207
Waukesha, WI 53188
(414) 547-6557

Building Families through Adoption
P.O. Box 248
Wautoma, WI 54982
(414) 787-3359

Catholic Charities, Inc.
128 South 6th Street, P.O. Box 266
LaCrosse, WI 54601
(608) 782-0704

Catholic Social Services, Green Bay
P.O. Box 1825
Green Bay, WI 54305-5825
(414) 437-6541

Catholic Social Services, Madison
4905 Schofield Street
Monona, WI 53716
(608) 221-2000

Catholic Social Services, Milwaukee
2021 North 60th Street
Milwaukee, WI 53208
(414) 771-2881

Children's Service Society of Wisconsin
1212 South 70th Street
West Allis, WI 53214
(414) 453-1400

Community Adoption Center
101 East Milwaukee, #322
Janesville, WI 53545
(608) 756-0405

Evangelical Child Family Agency
2401 North Mayfair Road
Milwaukee, WI 53226
(414) 476-9550

Hope International Family Services, Inc.
421 South Main Street
Stillwater, MN 55082
(612) 439-2446

Jewish Family Services
1360 N. Prospect Ave.
Milwaukee, WI
(414) 273-6575

LDS (Latter Day Saints) Social Services
4864 South 10th Street
Milwaukee, WI 53211
(414) 483-1352

Lutheran Counseling and Family Services
3515 North 124th Street
Brookfield, WI
(414) 783-4564
Mailing address: P.O. Box 13367
Wauwatosa, WI 53213

Lutheran Social Services of Wisconsin and Upper Michigan
3200 West Highland Boulevard
Milwaukee, WI 53208
(414) 342-7175

Northern Family Services
1835 Stevens Street, P.O. Box 237
Rhinelander, WI 54501
(715) 369-1554

Pauquette Children's Services, Inc.
P.O. Box 162
315 West Conant Street
Portage, WI 53901-8004
(608) 742-8004

Seven Sorrows Infant Home
Route 2, Box 905
Necedah, WI 54646
(608) 565-2417

Sunny Ridge Family Center, Inc.
c/o Bethel Baptist Church
1601 Libal Street
Green Bay, WI 54301
(414) 437-2040

Wisconsin Lutheran Child and Family Services
6800 North 76th Street
Milwaukee, WI 53219
(414) 353-5000■

ance. The Hotline also provides information on the Health Insurance Risk Sharing Plan, group insurance continuation and conversion rights, and health maintenance organization plans for Medicare beneficiaries.

Typical questions anwered at the Hotline are:

—How will my health insurance needs change when I reach 65?

—What Medicare supplement plans are currently available in Wisconsin?

—Does any Medicare supplement plan pay for everything Medicare doesn't?

—How does one supplement policy's benefits compare to another?

—Is there an HMO plan available to Medicare beneficiaries in my area?

—Should I continue with my group insurance when I retire?

Access to the Medigap Hotline is by calling 1-800-242-1060, Monday through Friday, 8:00 am–4:30 pm.

Board on Aging and Long-Term Care Offices:

(Main Office)
122 E Dayton St
Madison, WI 53703
(608) 266-8944

(Milwaukee Regional Office)
819 N Sixth St, Room 619
Milwaukee, WI 53203-1664
(414) 224-4386

(Wausau Regional Office)
212 River Drive
Wausau, WI 54401
(715) 847-5251

Ombudsman
Board on Aging
and Long-Term Care
505 Dewey St South
Eau Claire, WI 54701■

Guidelines on physician extenders in nursing homes

As developed by the SMS Committee on Aging, Extended Care Facilities and Home Health Care and adopted by the Board of Directors at its August 29, 1987, meeting.

By the year 2030, there will be approximately 50 million Americans over the age of 65, or one out of every five people in the US. Of these, those over 75 will soon represent the majority of the aged. This is the group most likely to develop multiple physical, psychological, and social problems. Twenty percent of them will spend some time in nursing homes.

Traditionally, nursing homes have received the least amount of attention in our training programs, in nursing schools, medical schools, and training at all levels. There are serious problems with staff recruitment, low wages, difficult working conditions and inadequate environments, especially when compared to the more attractive acute-care setting. These problems have contributed to the low level of attention paid to the health care needs of this population.

Physicians have often continued their role in nursing homes for a variety of reasons, including a long-standing obligation to the patient, family, or community. But a number of factors have contributed to the difficulty of the physician in providing the quality of care which we would all like to see practiced. These include distance from the clinic or hospital, number of patients, rules and regulations, reimbursement limitations, and access to necessary equipment on a timely basis. An increased effort is being made by all providers to improve the quality of care being delivered in nursing homes.

A recent study found that the most significant problems encountered in the care of nursing home patients include the lack of:

- physician services;
- auxiliary full-time staff (dentist, podiatrist, audiologist, speech pathologist, psychiatrist);
- complete physical, mental and functional assessments;
- physician communication with nursing home staff;
- continuous monitoring of health problems and proper laboratory follow-up;
- monitoring of medications;
- accident prevention (eg falls); and
- inservice education.

It does not appear likely that in the near future there will be an excess of physicians to provide the care needed by the growing population. A review of projected physician supply and need for physicians, as presented in 1976 in the GMENAC report, requires some revision of its reported expectations.

It is now anticipated that there will continue to be a need for primary care physicians. It is unlikely that physicians will choose to practice in the underserved, low-prestige setting of nursing homes without additional incentives. Although the supply of physician extenders has not been as large as that anticipated in 1976, the physician extender is still an available resource to assist in the delivery of care to the elderly in nursing homes.

Physician extenders can help where physicians are in short supply. They can cost-effectively perform routine tasks under physician supervision. They allow physicians to spend more time on complex services or critical medical problems. They can assist physicians in serving a population which is often underserved. In no way is the placement or use of a physician extender in the nursing home setting intended to decrease the physician involvement necessary to ensure that quality medical care is delivered. Instead, they are seen as a complement to the physician's work in the nursing home. Use of the physician extender in this setting must also comply with state and federal regulations and standards.

In a survey of administrators of a demonstration project with nurse practitioners, it was found that the impact on quality included (in decreasing frequency):

- improvement in continuity because they are able to see the patient on a more routine, even daily basis;
- earlier detection of problems;
- improved monitoring of drug use and side effects;
- increased number and quality of patient care plans;
- reduced physician response time to calls from the facility;
- improved abilities of nurses and nurse's aides;
- improved resident and family satisfaction; and
- improved infection control.

The noted impact on cost containment, in descending order of frequency, included:

- improved image of the facility in the community;
- improved staff morale;
- reduced unnecessary physician visits;
- reduced transfers to acute care;
- decreased drug costs; and
- reduced staff turnover.

Current status in Wisconsin

Physician extenders are recognized, licensed and employed in various health care settings of rural and urban Wisconsin, including hospitals, clinics and home care sites. There has been an interest in using them in the nursing home setting, but interpretation of the federal regulations has prohibited their active and frequent use. Recently, there has been increasing public and political pressure to reassess this prohibition.

SMS Resolution 14—1986 (Appendix A) resolves that the State Medical Society of Wisconsin support use of physician extenders to provide care for patients in nursing homes and requests an outline of the functions of physician extenders in that setting.

After extensive research, this committee supports the use of physician extenders in nursing homes under the supervision of physicians in Wisconsin. This is consistent with the SMS statement on joint practice, approved in 1974 (Appendix A), which refers to nurse practitioners and is extended to include physician assistants. Physician extenders are defined as nurse practitioners and physician assistants for the purpose of this resolution. Detailed definitions of physician extenders and supervision can be found in Appendix B. Following are guidelines on the use of the physician extender, given current standards and regulations.

Guidelines

In general, physicians may delegate to physician extenders medical procedures and other tasks which are performed within the normal scope of the physicians' practice. The practice of physician extenders may not exceed their training or experience and may not exceed the scope of practice of the supervising physician. Tasks assigned by the supervising physician to a physician assistant may not be delegated by that person to another person. Physicians are referred to Wisconsin Administrative Code, Chapter Med 8, for details of the rules governing physician assistants and to Wisconsin Administrative Code, N, Chapters 1 through 7, Rules of Board of Nursing.

Initiating the use of physician extenders

When initiating this arrangement in the nursing home, it is advisable to begin with the director of nursing and administrator to define arrangements and establish cooperation and support. A procedure to reconfirm support by an annual review and adoption of protocols and work arrangements in principle may also be advisable. (Clinical review of protocol would be the responsibility of the medical staff by whatever means it designates, including assignment to the UR/QA committee or medical director.)

The responsibilities of physician extenders should be clearly defined for all personnel. Tasks which they may and may not perform in the nursing home must be specifically defined. Strong consideration and effort should be given to discussion and education with staff prior to the initiation of the service.

Organizational arrangement

The organizational arrangement between physician extenders, nursing homes and physicians may vary. Physician extenders may be in the employ of the physician, a group of physicians, or the nursing home. The clinical work, however, must always be under the supervision of a designated physician for each patient. (One physician may not supervise more than two physician assistants.) Examples of current arrangements include a physician extender in the employment of one physician; a physician extender working for a group of physicians; a team of physician extenders in the employ of a medicine staff of 20, assigned as a group to nursing home patients, directly supervised by each patient's attending physician; and a physician extender in the employ of the nursing home, working directly with the patients attending the residents. Variations on these arrangements are possible.

Regardless of the specific arrangement, it will be necessary to define in advance specifics of the following relationships:

- the credentialing procedure in the medical or nursing department;
- their position in the organizational chart, eg under the medical director or director of nursing;
- who is responsible for hiring and firing;
- who is responsible for supervision of direct patient care and what that entails;
- who is responsible for supervision of other services to be provided, eg in-service education;
- clarification of who determines duties and use of time;
- who provides the peer review and quality assurance;
- the relationship to the director of nursing; and
- the relationship to the nursing staff.

Because physician extenders are functioning under the supervision of physicians and performing tasks

delegated by physicians, it is our recommendation that physician extenders be included under the medical staff bylaws, rules and regulations. Revisions may be necessary to address specifics on the credentialing process, duties and responsibilities, the development and use of written protocols, evidence of direct supervision to ensure quality, peer review by the medical staff, relationship to the medical director, and due process.

Defining the scope of practice

Physician extenders are trained in a wide range of technical procedures, in the normal and abnormal aspects of aging, comprehensive assessment skills (including the history and physical assessment of acute changes), common problems, and chronic disease management.

We are interested in how this training is put into practice. Legally, the scope of practice for the nurse practitioner is broadly defined by the Nurse Practice Act. The practice is not restricted by definitions, but is open to whatever the nurse practitioner and physician designate as their collaborative practice, which may or may not include written protocols. What might be considered medical acts are covered under this Act as "delegated medical acts." This would then be whatever the physician delegates and the nurse practitioner accepts, within their skill and knowledge.

For physician assistants, the scope of practice is specifically outlined in Med Chapter 8 of the Wisconsin State Statutes.

Therefore, the education and training of each individual and the Wisconsin licensure acts, in addition to the arrangement of the physician, ultimately define what skills and tasks can be performed by physician extenders. The following is a list of skills defined by Med Chapter 8 as being potentially within the scope of practice of a physician assistant:

- preadmission assessments;
- annual physical exam;
- technical procedures such as passing an NG tube;
- suturing and care of wounds (PA);
- routine therapeutic procedures, (eg immunizations);
- patient instruction and counseling on health, diet, and disease;
- assisting in rounds, recordkeeping, problem lists and case summaries;
- writing and executing standing orders or specific orders following consultation with and at the direction of the supervising physician;
- assisting in delivery of services by reviewing and monitoring treatment plans;
- discharge planning;
- facilitating referral to other appropriate community facilities and resources;
- preparing written prescription orders for drugs, other than controlled substances, if specifically directed to do so by the supervising physician and in accordance with procedures specified in Chapter Med 8.08(2);
- assessment, monitoring, and management of common acute and chronic health problems;
- infection control management; and
- psychosocial and functional assessment and goal articulation.

While it is acknowledged that many tasks are within the scope of practice of physician extenders, there are constraints on the actual use of them for all these tasks. Two major constraints are governmental regulations and standards and reimbursement practices.

Interpretation of practice and federal regulations

Under the current federal regulations, there are numerous tasks which are the responsibility of the physician in attendance. Some of the tasks must be carried out by the physician directly. Others may be delegated to another to perform, under the supervision of the physician. (Source: Correspondence between the Department of Health and Social Services and Bureau of Eligibility, Reimbursement and Coverage, Health Care Financing Administration, Dept. of Health and Human Services, August, 1986.)

1. Preadmission physician history and physical exam.

Regulations require that patients be admitted to a skilled nursing facility under the order of a physician and remain there under the care of a physician. The physician may delegate the history and physical to a physician extender with the physician assuming responsibility for reviewing the examination and signing the record of it. The physician remains the individual responsible for the recommendation for admission to the facility and must sign the appropriate authorizations for admission.

2. Evaluation of acute changes of conditions.

In response to a request from the nursing home, the physician may send the physician extender to evaluate the condition of the resident.

3. Order lab and x-ray studies.

Skilled nursing facility (SNF) regulations require that these services be provided only on the order of a physician. These orders may be given orally, directly to the nursing home nurse as long as they are promptly confirmed with written orders. They may not be ordered by the physician extenders.

Intermediate care facility (ICF) regulations are silent with "regard to orders for lab and x-ray services and they allow a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by state law," to order and provide these services. Therefore, a physician extender could order these for an ICF resident. An order for these tests must precede their being done.

4. Ordering medication.

Regulations require that only physicians may prescribe drugs, even over-the-counter drugs. ("Drugs are administered in accordance with written orders of the attending physician.") This applies to residents in SNFs and ICFs. Drugs can be prescribed orally by the physician, as long as they are confirmed promptly

with written orders, but the "SNF and ICF regulations provide that the physician's oral orders may be given only to a licensed nurse, a pharmacist, or another physician." This must be a direct communication with the licensed nurse in the facility and "cannot be conveyed from the physician through another individual in the physician's own office." This order must precede any change being made.

5. Written protocols.

Written protocols usually are general instructions that apply to any patient rather than to a specific patient and his or her situation. Routinely encountered, minor health problems common to the nursing home population are recognized by the regulations, such as bed sores, constipation, and dry skin, etc. When they occur, and are part of guidelines of established protocols and are treated pursuant to the physicians review and approval, it is not required that treatment be provided directly by the physician. Such problems can be identified and treated by physician extenders. This would not be seen as a violation of the federal regulations for SNFs and ICFs. This would apply whether the physician extenders were employed by the physician or nursing home.

6. Written protocols for medications.

Because written protocols are usually general and medication must be ordered by the physician, written protocols are generally not acceptable. There is, however, a way to use protocols if the protocol is specific for the patient involved. If the protocol provides for particular changes in dosage under specified conditions, changes would then be considered part of the physician's original drug order rather than a separate modification of the original drug order. In this situation, the physician extender would be implementing a contingency already provided for and not modifying the original drug order. In contrast, if the original drug order on the written protocol does not provide for specific adjustments and merely calls for reevaluation of the patient's condition at a particular point, the physician must then issue the new drug order at the point at which the reevaluation takes place.

7. Physicians required visit.

Only a physician can meet "the requirement that the patient be seen by the attending physician at least once every 30 days for the first 90 days following admission," that the total plan of care including medications and treatments be reviewed during a visit, and that a progress note be written and signed by the physician at this visit. These visits and duties cannot be delegated to physician extenders. The physician visits after the first 90 days must also be performed directly by a physician and cannot be delegated.

Interpretation of practice and state regulations

Wisconsin State regulations, implemented March 1, 1987, reflect the broader federal definition of physician extenders in the nursing home. Amendments to HSS 132 are included in Appendix C. In general, the revision allows physician extenders to perform the admission history and physical, and to participate in screening employees and in infection control. The federal requirements have precedence in the following areas: the physician certifies the patient is free of communicable diseases and orders the admission, the physician performs the required visits, and the physician orders medication and lab and x-rays, except where specifically noted in intermediate facilities.

Reimbursement for services performed by physician extenders

It is anticipated that current regulations defining reimbursement will be altered in the near future. The Omnibus Budget Reconciliation Act of 1986 has authorized an expansion of coverage of physician assistant services. This will be further defined on a federal level and then the Department of Health and Social Services will revise its guidelines as necessary.

In general, the basis for coverage of services is covered under Section 1861(s)(2)(A) of the Act. This authorizes payment for services "furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physician's offices, and are commonly rendered without charge or included in physicians' bills." These would refer to services by nonphysicians, commonly performed by employers of the physician under direct supervision (eg giving injections, taking temperatures and performing blood tests). Because a protocol for care of bed sores is not under the direct supervision of the physician, it would not be covered.

Services of the type that are typically performed by physicians are not covered under Section 1861(s)(2)(A) when done by a physician extender. This would include activities which require independent evaluation or treatment of the patient's condition and are appropriately performed by a physician. Examples are prescribing medication and setting casts on fractures. The Omnibus Budget Reconciliation Act expands the definition of coverable services under this category of Medicare.

Medicaid allows each state the discretion to design its own program under broader federal guidelines. The state may include medical or remedial care performed by state-licensed practitioners, done within their scope of practice. Thus, Medicaid payment for physician extender services depends on how the state defines its program.

In Wisconsin, there are specific guidelines on the reimbursement coverage for physician assistant services. They are listed in the Physician Services Handbook, Wisconsin Medical Assistance Program's Physician Services Handbook, Part K. It is developed by the Bureau of Health Care Financing of the Department of Health and Social Services and can be purchased for a nominal fee from Document Sales.

Services provided by nurse practitioners, which are reimbursed, are guided by the Nurse Practice Act. They are not specifically delineated at present by the

Bureau of Health Care Finance. For specific information, the Wisconsin Nurses Association will put you in contact with the appropriate person.

References

Wisconsin Nurses Association
6117 Monona Dr
Madison, WI 53716
608-221-0383

Wisconsin Academy of Physician Assistants
PO Box 1109
Madison, WI 53701
608-257-6781

Pertinent Administrative Codes and Regulations
Nursing: Wisconsin Administrative Code, Rules of Board of Nursing, N, Chapters 1 through 7.

Physician Assistant: Wisconsin Administrative Code, Med 8, Physician's Assistants, Wisconsin Medical Examining Board.

Physician Services Handbook, Wisconsin Medical Assistance Program's Physician Services Handbook, Part K.

Wisconsin Administrative Code. Chapter HSS 132., Nursing Home Rules.

These documents are available from:
Department of Administration
Document Sales and Distribution
202 Thornton Ave
Madison, WI 53702
608-266-3358

Appendix A

Definitions and Scope of Practice in Wisconsin

NURSE PRACTITIONER: a registered professional nurse who is currently licensed to practice in the state, who meets the state's requirements governing the qualifications of nurse practitioners, and who meets one of the following conditions:

(a) is currently certified as a primary care nurse practitioner by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates; or

(b) has satisfactorily completed a formal one academic year education program that:
   1. prepares registered nurses to perform an expanded role in the delivery of primary care;
   2. includes at least four months, in the aggregate of classroom instruction and a component of supervised clinical practice; and
   3. awards a degree, diploma or certificate to persons who successfully complete the program, or

(c) has successfully completed a formal educational program for preparing registered nurses to perform an expanded role in the delivery of primary care that does not meet the requirements of paragraph (b) of this definition.

PHYSICIAN ASSISTANT: a professional who practices under the supervision of a licensed physician and who has been certified by the Medical Examining Board under WI Administrative Code, Med Chapter 8 SS448. One of the requirements for state certificate is successful completion of the comprehensive examination of National Commission on Certification of Physician Assistants, which is administered by the National Board of Examiners.

PHYSICIAN EXTENDER: a person who is certified as a physician's assistant or nurse practitioner, acting under the direction of and supervised by a physician.

SUPERVISION: means to coordinate, direct and inspect continually the accomplishments of another, or to oversee with powers of direction and decision the implementation of one's own or another's intentions. (WI Admin. Code, Chapter 8.02).

Appendix B

State Medical Society of Wisconsin and Wisconsin Nurses Association Statement on Joint Practice

Approved by the Council of the State Medical Society of Wisconsin, May 18, 1974, and endorsed by the October 9–11, 1974 WNA House of Delegates and the State of Wisconsin Board of Nursing. The Medical Examining Board recognizes the need for the development of joint practice arrangements in accord with the principles enumerated in the Statement.

This Statement embodies guiding principles and professional opinion on elements of joint practice by physicians and registered nurses in any setting. The authority of the Statement testifies to mutually agreed upon principles of practice. The Statement can be used to validate generally acceptable practices or patterns of care and to respond effectively and responsibly to new needs and methods of providing care.[1]

The State Medical Society of Wisconsin and Wisconsin Nurses Association cannot through this Statement alter the legal authority of the physician or registered nurse. However, the application of the following principles of joint practice can substantially improve the quality, availability and accessibility of health care for the people of Wisconsin.

- The health and best interests of the recipients of care are foremost considerations in all practice arrangements.
- The degree of professional responsibility vested in the physician or registered nurse is related to education, experience, competence, and licensure. Each practitioner should perform only those acts for which that person has been prepared and has demonstrated ability to perform.
- Medical and nursing services are complementary but they are not interchangeable either in responsibility or accountability. Each practitioner is accountable and responsible for the quality of care rendered. Each practitioner is responsible for the maintenance and improvement of practice proficiency.
- Each practitioner should receive remuneration commensurate with qualifications and proficiency.

1. In developing this Statement the joint position statements on practice of the following medical and nurses associations were consulted and utilized: California, Canada, Florida and Idaho.

• Medical and nursing collaboration includes both independent and cooperative decision-making. Mutually developed protocols can clarify shared responsibilities and delegated functions.

• Educational programs for the preparation of registered nurse practitioners in extended roles should be developed by nursing in consultation with medicine and should be carried out, wherever possible, under the aegis of accredited educational institutions.

• It is advantageous to have physicians and registered nurses affiliate in joint practice committees in order to provide both with an organizational base, a collegial advisory group, and a channel of communication.

• In each health care delivery setting involving the practice of registered nurses and physicians, a joint practice committee should establish written policies and standards of performance. Such policies and standards should be reviewed periodically.

• It is important to maintain a flexible and innovative approach in the evolving role realignment of registered nurses and physicians. Differences in recipient populations, in how they are served, and in the composition of practitioners working in a setting, will influence what each practitioner regularly does.

Appendix C

HSS 132—Physician extender requirements

Effective Feb 1, 1987, HSS 132 was revised. In this revision, there are new provisions which cover the work of a physician extender in the nursing home setting. What follows is the pertinent sections which specifically apply to the physician extender functioning in this setting.

Definitions

SECTION 2. HSS 132.13(17), (23), and (24) are created to read:

HSS 132.13(17) "Nurse practitioner" means a registered professional nurse who meets the requirement of s HSS 105.20(2)(b).

HSS 132.13(23) "Physician extender" means a person who is a physician's assistant or a nurse practitioner acting under the general supervision and direction of a physician.

HSS 132.13(24) "Physician's assistant" means a person certified under ch. 448. Stats., to perform as a physician's assistant.

Employee health

SECTION 3: HSS 132.42(3)(a) and (4) are amended to read:

HSS 132.42(3) PHYSICAL HEALTH CERTIFICATIONS. (1) New employees. Every employee shall be certified in writing by a physician or physician extender as having been screened for tuberculosis infection and being free from clinically apparent communicable disease within 90 days before beginning work.

HSS 132.42(4) DISEASE SURVEILLANCE AND CONTROL. Facilities shall develop and implement written policies for control of communicable disease which ensure that employees and volunteers with symptoms or signs of communicable disease or infected skin lesions are not permitted to work unless authorized to do so by a physician or physician extender.

Documentation and medical records

SECTION 4. HSS 132.45(5)(b)1 is amended to read:

HSS 132.45(5)(b) Physician's documentation. 1. An admission medical evaluation by a physician or physician extender, including . . .

Admission to the nursing home

SECTION HSS 132.52(2)(a) and (b) are amended to read:

HSS 132.52(2) PHYSICIAN'S ORDERS. No person may be admitted as a resident except upon:
(a) Order of a physician;
(b) Receipt of information from a physician, before or on the day of admission, about the person's current medical condition and diagnosis, and receipt of a physician's initial plan of care and orders from a physician for immediate care of the resident; and
(c) Receipt of certification in writing from a physician that the person is free of communicable tuberculosis and clinically apparent communicable disease, or an order for procedures to treat any disease the person may be found to have.
(3) MEDICAL EXAMINATION AND EVALUATION. (a) Examination. Each resident shall have a physical examination by a physician or physician extender within 48 hours following admission unless an examination was performed within 15 days before admission.
(b) Evaluation. Within 48 hours after admission the physician or physician extender shall complete the resident's medical history and physical examination record.

Writing orders

SECTION 132.66(1)(d) Physician's order. No services under this subsection may be provided without an order of a physician, except that services provided to intermediate nurse care residents may be provided under the order of a physician or physician extender.

Appendix D

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Wisconsin Administrative Code. Med Chapter 8. Physician Assistants.■

PartnerCare to begin second year on high note

PartnerCare emerged in 1987-1988 as the premier voluntary Medicare assignment program in the country. Virtually all Wisconsin counties take part in the program, which features 5,000 physicians and more than 4,000 enrollees. In addition, a PartnerCare working group was established at the Society's Annual Meeting in May 1988 which will examine ongoing and emerging program issues.

The successful venture represents another productive collaboration between the Society and the Coalition of Wisconsin Aging Groups (CWAG). The Society and coalition first teamed up in 1984 to initiate similar pilot programs for low-income seniors in selected areas. Building on that earlier effort, the two organizations announced the introduction of PartnerCare at the Society's Annual Meeting in March 1987.

"Our revitalized program ensures that seniors experiencing financial difficulty receive needed medical care—when they need it most," proclaimed Kenneth M. Viste, Jr, MD, SMS's immediate past president. Dr Viste served as PartnerCare's ambassador at large during his year as president in 1987-1988, traveling to countless county medical society meetings, physician offices and clinics. Dr Viste was joined by Thomas L. Adams, SMS's secretary-general manager, and other SMS representatives in enlisting physician support for PartnerCare.

Thomas L. Frazier, CWAG's executive director, spearheaded his organization's involvement with the joint enterprise. "PartnerCare addresses three major health care problems of lower-income older persons," he said. "The program will reduce out-of-pocket expenses, alleviate the Medicare paperwork burden, and promote preventive care by allowing seniors to avoid deferring care."

The coalition deployed a program coordinator and a cadre of Volunteers In Service to America (VISTA) workers to train elderly volunteers and county office on aging staff to enroll elderly into PartnerCare. While local steering committees were often formed to oversee the implementation of PartnerCare in their respective counties, county offices on aging act as the ongoing vehicle for PartnerCare enrollment and promotion. This reflects the grass roots philosophy of meeting local needs at the local level also demonstrated in the pre-PartnerCare pilot programs.

"Close coordination between the different players allowed us to get PartnerCare up and running in a compressed time frame," said Frank Vogel, SMS policy analyst and PartnerCare's program manager. Betty Morey, CWAG's program coordinator, agreed that "regular communication was, and remains, key to our steady progress."

Tom Adams noted that "Wisconsin came out early and came out strong" in launching a statewide voluntary program. "Other state and county medical societies nationwide look to us as the leader in this regard."

Meanwhile, the PartnerCare working group, chaired by Dr Viste, will begin meeting in July, and will serve as a high-level forum for deliberation of various issues affecting PartnerCare's operation.■

Charter Law of Medical Societies

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, bylaws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, bylaws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, bylaws and regulations of the state society.

148.03 Service insurance corporations for health care. The state medical society or, in a manner approved by the state society, a county society, may establish in one or more counties of this state a service insurance corporation for health care under ch. 613.

NOTE ON ss. 148.03, 447.13, 449.15 and 450.13; Chapter 613 provides in general terms for the creation, governance and regulation of service insurance corporations for any kind of health care, as well as for other types of services. All that is needed in each authorizing chapter for professional societies is a brief section giving the appropriate professional society the power to organize a ch. 613 corporation. Section 148.03 creates that section for health care.

One basic restriction results from the repeal of the old enabling sections: none of the professional societies will be able to organize a service insurance plan within its own corporate structure. It is a mistake to permit such a mixing of professional and insurance activities within the same corporation. The society can, of course, control the service insurance corporation it creates under ch. 613, but the service insurance corporation will be legally separate. This will lead to more effective (and appropriate) control by the insurance commissioner, who should neither be empowered nor compelled, as arguably he was under the old statutes, to have any concern about the purely professional activities of the societies, because of the impossibility of disentangling the insurance and professional activities carried on by a single corporation. ■

1841—The Society created by territorial legislation

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . .well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art. . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . .a society under the name and style of the Medical Society of the Territory of Wisconsin. ." Drs. Bushnell B. Cary, M.C. Darling, Lucius L. Barber, Oliver E. Strong, Edward McSherry, E.W. Wolcott, J.C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B.O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society.

CONSTITUTION AND BYLAWS
of the State Medical Society of Wisconsin

CONSTITUTION

ARTICLE I
Name of the Association

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II
Purpose

The purpose of the Society is to bring together the physicians of the state of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws. As used in the Constitution or Bylaws, "physician" means a doctor of medicine or a doctor of osteopathy licensed in Wisconsin.

ARTICLE III
Component Societies

Component societies shall consist of those county medical societies chartered by the House of Delegates of this Society.

ARTICLE IV
Composition of the Association

This Society shall consist of members who shall be the members of and certified by the component county medical societies; and whose dues and assessments for the current year have been received by the Society secretary in accordance with the schedule provided in the Bylaws.

ARTICLE V
House of Delegates

The House of Delegates shall be the legislative body of the Society, and shall consist of:

(1) delegates elected by the component county medical societies,
(2) one delegate representing each specialty section of the Society organized under the Bylaws,
(3) a speaker,
(4) a vice speaker.

The officers of the Society enumerated in Article IX of this Constitution, directors, and past presidents of the Society shall be ex officio members, but without the right to vote, except that if they have been duly seated as delegates, they shall have the right to vote.

The speaker and vice speaker shall be elected by and from the House of Delegates for two-year terms, and shall be limited to three consecutive full terms in their respective offices. While holding these offices, they shall be members of the House at large and shall not represent any component county society or specialty section.

ARTICLE VI
Board of Directors

The Board of Directors, hereinafter referred to as "Board," shall have full authority and power of the House of Delegates between sessions of the House. It shall consist of the directors, immediate past president, president, president-elect, speaker and vice speaker of the House of Delegates. The secretary and the treasurer shall be ex officio members of the Board, but without the right to vote. A majority of its voting members shall constitute a quorum.

Directors shall be elected from eight geographic districts whose boundaries shall be determined by the House of Delegates. There shall be elected one director from each district, except that in any district with 200 or more regular and special members, there shall be elected one additional director for each additional 200 members or majority fraction thereof. As nearly as possible, one-third of the members of the Board shall be elected each year.

Each director shall be nominated and elected only by the elected delegates of the county medical society or societies from the district in which the director's principal place of practice is located. Such election shall be subject to the approval and confirmation of the House of Delegates.

The terms of the directors shall be for three years. No individual shall be permitted to serve more than three consecutive three-year terms as director, and no more than a total of six terms of service as director shall be permitted.

ARTICLE VII
Specialty Sections

The House of Delegates shall provide for a division of the Society into specialty sections.

ARTICLE VIII
Meetings

Section 1. The Society shall hold an Annual Meeting, at which time the House of Delegates shall meet to conduct its business. The Annual Meeting may also include scientific sessions as determined by the Board.

Sec. 2. The place for holding each Annual Meeting shall be fixed by the House of Delegates, or by failure to act, such authority is delegated to the Board. The time and the place for holding each Annual Meeting shall be approved by the Board.

Sec. 3. Special meetings of the House of Delegates shall be called by the speaker on written request of twenty delegates representing at least 10% of the component county medical societies, or on request of a majority of the Board. When a special meeting is called, the speaker shall set the time and place. The secretary shall mail a notice to the last known address of each member of the House of Delegates at least twenty days before the date of the special meeting. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall consider no business except that for which it is called.

ARTICLE IX
Officers

Officers of this Society shall be a president, a president-elect, a secretary, and a treasurer. The president-elect and treasurer shall be elected annually by the House of Delegates. The secretary shall be elected annually by the Board. The

Adopted as amended by the House of Delegates, March 26–27, 1987.

president-elect shall automatically succeed to the office of president at the conclusion of the term as president-elect. The treasurer shall be limited to nine consecutive terms.

No person shall hold more than one of the following offices concurrently: president, president-elect, secretary, treasurer, speaker, vice speaker, director. Incumbents shall serve until their successors are elected and installed.

ARTICLE X
Funds and Expenses

Funds may be raised by annual dues or by assessment on the members, or in any other manner approved by the House of Delegates. The House may establish regular and special classifications of membership. Dues, if any, shall be applied equitably to all members in each class.

All resolutions adopted by the House of Delegates providing for appropriations shall be referred to the Board for implementation. All expenditures approved by the Board shall be included in the annual budget.

ARTICLE XI
Referendum

The House of Delegates may, by a two-thirds vote of those registered at that session, submit any question to the membership of the Society for its vote, except amendments to the Constitution. Such amendments are governed by Article XIII. The House shall determine prior to submission whether a referendum shall be advisory or binding, and so advise the membership at the time of submission. A majority vote of all the members of the Society shall determine the question on a binding referendum.

ARTICLE XII
Seal

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII
Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any Annual Meeting, provided that such amendment shall have been introduced in the form of a constitutional amendment in open session at the previous Annual Meeting, and that it shall have been published at least once during the year in the Journal of this Society, or sent to each member of the Society at least two months before the meeting at which final action is to be taken.

BYLAWS

CHAPTER 1
Membership

Section 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of the county society, shall be *prima facie* evidence of membership and of the right to benefits.

Sec. 2. No person whose name has been dropped from the roll of members of a component society or this Society shall be entitled to any of the rights or benefits of this Society, except that such rights and benefits shall continue during the period of an appeal by such person to the Board of Directors.

Sec. 3. Every physician who holds a license to practice medicine and surgery in Wisconsin shall be eligible to apply for membership. Each county society shall be the judge of the initial and continuing qualifications of its members, as well as the appropriate membership classification, subject to review and final decision by the Board of this Society. Members will conduct themselves in a manner which is not in conflict with the purposes for which the Society is organized and is operating.

Sec. 4. By provision of its constitution or bylaws, a county society may require that an applicant shall have practiced within its jurisdiction for a period of one year as a condition for election to membership; or that an applicant may first be elected to membership for a term of one year only, then resubmit to election by vote of the county society without limitations as to term.

Sec. 5. A member of a component society whose license has been revoked, suspended, nonrenewed, or voluntarily surrendered, shall be immediately and automatically suspended from membership as of the date of revocation, suspension, nonrenewal, or voluntary surrender, pending definitive action by the Board.

Sec. 6. A physician's county society membership must be held in that county in which the physician's principal practice is located. However, a physician living near a county line may hold membership in that county most convenient for attending meetings, with concurrence of the component society in which the principal place of practice is maintained.

Sec. 7. A member whose principal practice is moved from within the territorial limits of a component medical society to the territory of another component of the State Society shall not be eligible to continue membership in the first such society after the expiration of the calendar year in which such move shall have occurred. Such member shall, however, be eligible to apply for membership anew, or by transfer to the society into whose jurisdiction the principal practice has been moved. The member shall be given a written certificate of transfer for transmission to the secretary of the society in the county to which he has moved. Pending acceptance or rejection by the society in the county to which he has moved, such member shall be considered to be in good standing in the first society and in the State Society until the end of the period for which dues have been paid.

Sec. 8. When the principal practice of a member in good standing in a component society is moved outside the borders of this state, active membership in such component society and in the State Society may be continued by fulfilling all requirements of membership except residence pending acceptance as a new or transfer member by the society of the area to which the practice has been transferred. The period of such continuing membership in this state shall cease upon acceptance by a society in the new area of practice, and shall in no event continue beyond two full calendar years after that in which the practice location has been transferred.

Sec. 9. *Membership Classifications.* Members defined in this section, except Affiliates, shall have all the rights and privileges of the Society and shall pay dues and assessments, as indicated, as a requirement of continued membership.

A. *Regular.* Regular members of this Society consist of all the regular members in good standing of the component county societies.

B. *Special.* Included in this classification are the following categories of members who by virtue of their special circumstances are entitled to reduced dues or waiver thereof:

(1) *Part-time practice.* Any physician, regardless of age, who practices 1,000 hours or less during a calendar year, but does not qualify under section 9.B. (5), may upon application, recommendation by the

county medical society, and approval by this Society, be placed in this special category.

(2) *Resident.* Physicians in approved training programs as hospital residents or as research fellows who are licensed to practice medicine and surgery in Wisconsin. Such special membership category can be maintained for a maximum of five (5) consecutive years.

(3) *Temporary Military Service.* Members who are inducted into the United States Military or Public Health Service and serve in such capacity for not more than five (5) years.

(4) *Associate.* Members who suffer a disability preventing them from practicing medicine with resulting serious financial reverses which would make the payment of dues a matter of personal hardship. Such membership shall be on an annual basis, upon recommendation of the county society and approval by the Board of this Society.

(5) *Retired.* Members who have retired completely from the practice of medicine, or who practice 240 hours or less during a calendar year, upon recommendation of the county society and approval by this Society.

(6) *Life.* Those members of the State Medical Society of Wisconsin who have been members of this or other state medical societies for fifty (50) years, or are past presidents of the State Medical Society of Wisconsin. They shall receive a certificate of Life Membership.

(7) *Honorary.* Members who have been elected to a similar classification by their county society because of outstanding contributions to the medical profession, upon approval by the Board of this Society.

(8) *Over Age 70.* Members who are age 70 effective January 1 of the following year.

C. *Affiliate.* Persons who are not otherwise eligible for membership may become affiliated with this Society in one of the following categories. Their dues or assessments, as well as rights and privileges as affiliate members, shall be determined by the Board.

(1) *Candidate.* Upon application, a county medical society or this Society may confer upon any person then attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure the status of Candidate Member.

(2) *Scientific Fellow.* The Board may by invitation and unanimous consent confer upon any person engaged in teaching of or research in one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy, the status of Scientific Fellow.

(3) *Emeritus.* Retired members who have chosen not to renew their license, at the discretion of the Board.

Sec. 10. *Dues and Assessments.* Members shall pay dues and assessments as follows:

A. *Regular members:* full dues and assessments.

B. *Physicians in part-time practice or over age 70:* one-half of regular member dues and assessments.

C. *Physicians in residency or fellowship training:* dues and assessments to be determined by the board of directors.

Dues and assessments for all other categories shall be waived, except as may be determined by the Board for affiliate members.

CHAPTER II
House of Delegates

Section 1. Each component county society shall be entitled to send one delegate and one alternate to the House of Delegates for each forty regular and special members or majority fraction thereof in this Society, provided, however, that each county society shall be entitled to at least one delegate and one alternate from that county society.

For purposes of this section, the number of members as of the close of the calendar year preceding the first session of the House of Delegates at the Annual Meeting shall determine the number of delegates to which a county society shall be entitled.

The secretary of each county society will send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve.

Sec. 2. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

Sec. 3. The speaker shall preside at the meetings of the House of Delegates.

Sec. 4. The vice speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice speaker shall officiate during the unexpired term.

Sec. 5. The speaker shall appoint members of reference committees from among the members of the House of Delegates. These committees shall consider and make recommendations to the House relative to resolutions, reports of officers, reports of commissions and committees, financial and other matters germane to the business of the House. The speaker shall also appoint a credentials committee and such other committees as deemed necessary.

Sec. 6. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Sec. 7. The House of Delegates shall have authority to create committees for special purposes and to appoint members of the Society who need not be members of the House of Delegates. Such committees shall report to the House of Delegates, and their members may be present to participate in the debate on their reports.

Sec. 8. It shall receive for appropriate action the annual reports of the treasurer, secretary, and chairman of the Board of Directors.

Sec. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society two months before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Board of Directors or any member thereof, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

Sec. 10. All questions of an ethical nature brought before the House of Delegates shall be referred to the Board of Directors without discussion.

CHAPTER III
Annual Election

Section 1. The House of Delegates, at its first session of the Annual Meeting, shall elect a Committee on Nominations consisting of one (1) delegate for each district, except

that in any district having five hundred (500) or more regular and special members, there shall be elected one (1) additional delegate for each additional five hundred (500) members or majority fraction thereof. One (1) delegate representing the specialty sections shall also be appointed. This committee shall become operative at the close of the final session of that Annual Meeting and shall function until the close of the final session of the following year's Annual Meeting. The incoming committee shall meet with the existent committee but without vote during the overlapping days of the Annual Meeting. Any vacancy occurring in the Committee on Nominations between the date of its formation and the time of its reporting shall be filled by appointment by the director or directors of the district in which the vacancy occurs, provided that if the vacancy occurs in the representation from the specialty sections, such vacancy shall be filled by ballot from among the section delegates.

The Committee on Nominations shall convene at least two (2) months prior to the Annual Meeting of the House of Delegates to prepare a slate of candidates. This meeting, to be held at a time, date and location published to the general membership at least two (2) months before this meeting, shall include an open session of not less than one (1) hour to allow individual nomination of candidates. The Committee shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the positions to be filled.

Sec. 2. The report of the Committee on Nominations and elections shall be the first order of business of the House of Delegates at the third session of the Annual Meeting.

Sec. 3. The House of Delegates shall elect the president-elect, the treasurer, the speaker and vice speaker of the House of Delegates, and the delegates and alternates to the American Medical Association. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by separate ballot for each individual position, and a majority of the votes cast shall be necessary to elect. If no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped, except where there is a tie, and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of the votes cast.

Sec. 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

CHAPTER IV
Duties of Officers

Section 1. The president is the chief constitutional officer of the Society. Within the limits of the Constitution, Bylaws, and policies of the House of Delegates and Board of Directors, the president shall have the following responsibilities and commensurate authority:

a. Deliver an annual address to the House;
b. Serve as a member with right to vote on the Board;
c. Preside at meetings of the Executive Committee of the Board;
d. Participate, ex officio and without the right to vote, in sessions of the House;
e. Initiate and propose policies and programs that will further the goals and objectives of the Society for consideration by the House, Board, commissions and committees;
f. Support and articulate policies and programs adopted by the Board and the House;
g. Promote physician interest and active participation in the Society.

Sec. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant, the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect, the Board shall appoint one of its members as acting president until the next meeting of the House of Delegates.

Sec. 3. The treasurer shall be responsible to the Board of Directors, and shall advise and assist it in making decisions on investment policy and financial matters. The duties of the treasurer shall include the following:

a. Be responsible for all funds due the Society, together with bequests and donations;
b. Pay money out of the treasury only on written order of the secretary;
c. Subject the treasurer's accounts to such examination as the House of Delegates may order;
d. Annually report on the financial standing of the Society, including a balance sheet and income and expense report;
e. Give bond in such amount as the Board may provide.

Sec. 4. The Secretary is the chief executive officer of the Society charged with the execution of policy as created and defined by the House of Delegates and the Board of Directors. The Secretary shall serve as an ex officio, nonvoting member of the Board; be responsible to the Board and serve as its secretary; assist the Board and officers in making decisions and implementing actions; share convictions and argue their merits; perform the functions ordinarily assigned to the office of Secretary, and make an annual report to the House of Delegates.

"As chief executive officer the Secretary shall, within the limits of the Constitution and Bylaws and Board operating policies, effectively perform the general managerial function for the Society and all of its divisions, activities, and personnel including employment and, as necessary, termination of all employees; be responsible for and have the necessary authority to direct, supervise, and coordinate all programs, projects and major activities of the Society and all wholly-owned subsidiaries; formulate and recommend for approval of the Board basic policies and programs which will seek to achieve the objectives and goals of the Society; fully inform the Board on the condition and operation of the association; cooperate with the Board and Treasurer in establishing a program of fiscal responsibility for the Society including development, recommendation and, upon approval, operation within an annual budget; act to insure that all funds, physical assets, and other property of the Society are appropriately safeguarded and administered; develop and maintain effective internal and external communications with the membership and other organizations and agencies, both public and private, so as to enhance the positions of the Society and the objectives of its membership; and through effective management and leadership, achieve economic, productive performance, forward-looking programming, and constructive growth of the Society."

Note: Following adoption of this Bylaw change (Sec. 4 above) in 1987, the Board agreed to develop and maintain a set of current "operating policies" between itself and the Secretary to detail the more specific duties and expectations important to a good working relationship between the Board and the Secretary.

CHAPTER V
Board of Directors

Section 1. The Board of Directors shall be the executive body of the Society. Between meetings of the House of Delegates it shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws.

Sec. 2. The Board shall meet during the Annual Meeting and at such other times as necessity may require, subject to the call of the chairman or on petition of three directors. It shall hold an annual meeting for purposes of organization and other business.

Sec. 3. The Board shall elect a chairman and a vice chairman from among its voting members. It may create such further offices or combine or abolish them as it sees fit in the management of its affairs and in the discharge of its responsibilities. Its chairman shall submit an annual report to the House of Delegates including all major actions and policy decisions of the preceding year.

Sec. 4. Each director shall be the organizer and mediator for the district. Directors shall visit each county in their district as needed for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep informed of the activities of the component societies in the district. Each director shall arrange for an annual conference or caucus with the societies or their delegates within the district, at which time information shall be disseminated concerning the activities of the State Medical Society and component societies within the district. Each director shall report as necessary to the Board. The necessary traveling expenses incurred by each director in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include the expense of attending the Annual Meeting of the Society.

Sec. 5. The Board of Directors shall be the judicial body of the Society. It may decide any questions of conduct or discipline of members, or any questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. It shall develop and publish procedures for discipline, including denial of initial or continuing membership, for those physicians who fail to provide quality health care, failure to pay dues, loss of license to practice, or other cause. Its decisions in all cases shall be final, including the right to expel a member should a component society fail to do so after being so requested by the Board.

The Board's right to original jurisdiction includes but is not limited to the right to decide cases when:

a. the affected parties reside within the boundaries of a single county medical society and that society does not wish to assume jurisdiction;
b. the affected parties reside in two or more component medical society jurisdictions.

The Board also has within its authority the right to appoint a commission or commissions to which any or all such matters may be referred for investigation, evaluation and decision to acquit, admonish, or otherwise discipline as appropriate. A member may appeal to the Board the decision of such commission or the action of a county society as provided in Chapter X, Section 3. If the recommendation is for suspension or expulsion of a physician from Society membership, final action must be taken by the Board.

Sec. 6. Charters shall be issued to county societies only on approval of the Board, with ratification by the House of Delegates, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Board, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Sec. 7. In sparsely settled sections, the Board shall have authority to organize the physicians of two or more counties into societies. These societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Sec. 8. The Board shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have the authority to appoint an editor of the Journal and such assistants as it deems necessary.

Sec. 9. The Board shall select a qualified independent accounting firm and receive an annual audit of all accounts of this Society. With the treasurer, it shall supervise the investment of funds. The Board shall adopt an annual budget providing for the necessary expenses of the Society.

Sec. 10. The Board may, by interim appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between Annual Meetings of the House of Delegates. The appointee shall serve until a successor has been elected and has qualified.

When a district initially qualifies for an additional director, such position shall be considered new and not a vacancy to which the Board is authorized to make an interim appointment. Such new position shall be filled by election at the next meeting of the House of Delegates in the manner provided by Article VI of the Constitution. The initial term shall be so established as to maintain the election of substantially one-third of the directors each year.

Sec. 11. The Board may elect as secretary one who need not be a physician or a member of the Society.

Sec. 12. The Board shall provide such facilities for the Society as may be required to properly conduct its business.

CHAPTER VI
Commissions and Committees

Section 1. The Board shall appoint such commissions and committees, either permanent or ad hoc, as it deems necessary to properly conduct the affairs of the Society. Membership on such committees and commissions shall be limited to members of the Society and its Auxiliary. Nonmembers of the Society or its Auxiliary may be appointed as special representatives should their expertise and knowledge be of benefit to the goals of such commissions or committees. Such individuals shall not have the right to vote or hold office.

Each commission and committee shall have the duty of being informed on matters within the area of its special interest. They shall represent the Society's interests by continual contacts with voluntary and governmental agencies having related concerns with the intention of coordinating efforts to serve the health interests of the people of Wisconsin. They shall develop recommendations from their studies and activities for action by the Board or House of Delegates.

Sec. 2. Specialty sections shall be regarded as special committees of the Society from which the Board or any commission or committee may seek advice and assistance on matters of special or general concern to the profession and the health of the people of Wisconsin. The specialty sections will be expected to give special requests prompt consideration and response so as to enable the Society to make maximum use of their resources.

CHAPTER VII
Dues and Assessments

Section 1. The annual dues and assessments of this Society shall be determined by the House of Delegates and shall be levied per capita on the members. Dues and assessments shall be payable as determined by the Board of Directors. Any member whose current year's dues have not been received by the Secretary on or before the dues payment deadline, as established by the Board of Directors, shall be deemed in arrears and shall be removed from the membership rolls of the county society and this Society until such time as full dues for the current year have been received.

Sec. 2. The record of payment of dues and assessments on file in the offices of this Society shall be final as to the fact of payment by a member and to the right to participate in the business and proceedings of the Society or the House of Delegates and to any other benefits and privileges of membership.

CHAPTER VIII

The Board of Directors shall adopt ethical guidelines for the members of this Society.

COMMENT: On July 18, 1981 the Board of Directors adopted the Principles of Medical Ethics of the AMA as the ethical guidelines of the Society.

CHAPTER IX

The current edition of Sturgis Standard Code of Parliamentary Procedure governs this organization in all parliamentary situations that are not provided for in the law or in its charter, constitution, bylaws, or adopted rules.

CHAPTER X
County Societies

Section 1. All present county societies or those that may hereafter be organized in this state shall, upon application to the Board of Directors, receive charters from this Society, provided that their constitutions and bylaws have been submitted to the Board and found in conformity with the Constitution and Bylaws of the State Medical Society. All revisions shall be submitted to the Society, approved by the Board, and filed with the secretary. Where a county society has lost or misplaced its constitution and bylaws, the model constitution and bylaws for county medical societies, as last approved by the Board, shall be deemed to apply.

Sec. 2. Only one component medical society shall be chartered in each county.

Sec. 3. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Board of Directors of the State Society. Its decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Board of the State Society for final determination. The mechanisms and procedures which apply to the appeal process shall be those adopted by the Board.

Sec. 4. Each component county society shall elect one or more delegates and may elect an equal number of alternates to substitute for any absent delegates from that component society, for a term of two calendar years, to represent it in the House of Delegates of this Society, in accordance with Chapter II, Section 1, of these Bylaws. The term of office shall begin on January 1 of the year succeeding the election of such delegates and alternates.

Sec. 5. The secretary of each county society shall keep a roster of its members.

CHAPTER XI
Specialty Sections

Section 1. The House of Delegates shall establish specialty and special sections within the Society. It shall have the power to combine, enlarge, or discontinue any or all of such sections so established using the following guidelines:

a. For specialty section to be designated it must represent a specialty which is represented in the American Medical Association House of Delegates and
b. Have at least twenty (20) members of the specialty who are members of this Society.
c. If no representative from the specialty section registers as a representative of that section for three (3) consecutive Annual Meetings, the specialty section will be dropped with the option of reapplying after one year, provided the above criteria are met.
d. From time to time special sections not meeting the above criteria may be established by the House of Delegates.

Sec. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest. Qualifications for membership in any section shall be established by the members of such section, subject to approval of the Board of Directors. Scientific meetings of a section shall be open to all members in good standing of the State Medical Society.

Sec. 3. The officers of each section shall be elected by and from its membership. The terms of such officers shall be for one year, but any officer may be reelected.

Sec. 4. No section shall have the power to bind the State Medical Society by any resolution or other action. No such resolution or action shall be publicized unless it shall first have been approved by the House of Delegates, or by a majority of the Board when the House is not in session. No resolution adopted by any section shall be effective until likewise so approved.

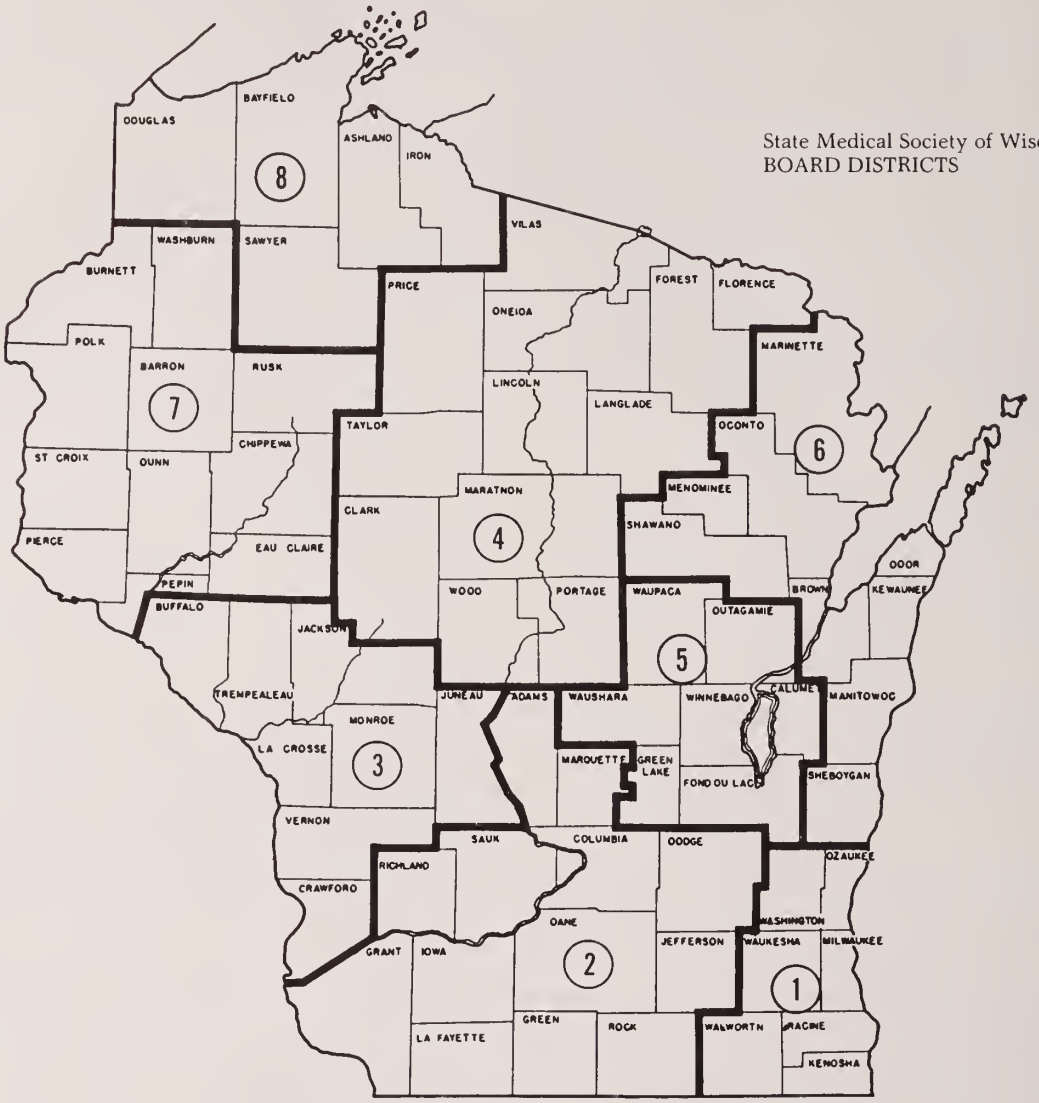
Sec. 5. Each section shall elect a delegate and an alternate to the House of Delegates. The term shall be for two calendar years without limitation on number of terms.

Sec. 6. The specialty sections of the Society shall be considered an integral part of the working committee structure of the Society as outlined in Chapter VI of these Bylaws.

CHAPTER XII
Amendments

These Bylaws may be amended at any Annual Meeting by a majority vote of the delegates present, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one session of that Annual Meeting. ■

BOARD DISTRICTS AND DIRECTORS: 1988–1989



District **Director**

1—Donald A Wollheim, MD, Milwaukee
Lucille B Glicklich, MD, Milwaukee
Wayne H Konetzki, MD, Waukesha
Richard H Strassburger, MD, Milwaukee
Frank H Urban, MD, Wauwatosa
William J Listwan, MD, West Bend
Thomas A Hofbauer, MD, Menomonee Falls
Marcia J S Richards, MD, Milwaukee
Huron L Ericson, MD, Racine
Raymond C Zastrow, MD, Milwaukee
Roger E Laubenheimer, MD, Milwaukee
Thomas A Reminga, MD, Milwaukee

2—Sandra L Osborn, MD, Madison
James J Tydrich, MD, Richland Center
Peter L Eichman, MD, Madison
Kenneth I Gold, MD, Beloit
James P Speichinger, MD, Madison
John D Wegenke, MD, Madison

3—Pauline M Jackson, MD, La Crosse

4—William E Raduege, MD, Woodruff
Robert J Jaeger, MD, Stevens Point
Richard H Ulmer, MD, Marshfield

5—Harry J Zemel, MD, Fond du Lac
James L Basiliere, MD, Oshkosh
Donn D Fuhrmann, MD, New London

6—Roger L von Heimburg, MD, Green Bay
Joseph C DiRaimondo, MD, Manitowoc
John E Kraus, MD, Marinette

7—Marwood E Wegner, MD, St Croix Falls
Philip J Happe, MD, Eau Claire

8—Robert L Sellers, MD, Superior

OFFICERS AND DIRECTORS: 1988–1989

State Medical Society of Wisconsin

Officers of the Society

President (1988–1989)
J D Kabler, MD, 1552 University Ave, Madison 53705

President-elect (1988–1989)
William L Treacy, MD, 10125 W North Ave, Milwaukee 53226

Secretary/General Manager (1988–1989)
Thomas L Adams, 330 E Lakeside St, PO Box 1109, Madison 53701

Treasurer (1988–1989)
John J Foley, MD, PO Box 427, Menomonee Falls 53501

Board of Directors

Chairman: *Roger L von Heimburg, MD*
Vice Chairman: *Richard H Ulmer, MD*

Directors (by districts)*

FIRST: Kenosha, Milwaukee, Ozaukee, Racine; Walworth, Washington, Waukesha Counties

Donald A Wollheim, MD (1988–1991): 3535 W Oklahoma Ave, Milwaukee 53215
Richard H Strassburger, MD (1988–1991): 161 W Wisconsin Ave, Milwaukee 53203
Raymond C Zastrow, MD (1987–1989): 2400 W Villard Ave, Milwaukee 53209
Roger E Laubenheimer, MD (1986–1989): 324 E Wisconsin Ave, #935, Milwaukee 53202
Thomas A Reminga, MD (1986–1989): 2025 E Newport Ave, Milwaukee 53211
Thomas A Hofbauer, MD (1987–1990): PO Box 427, Menomonee Falls 53051
Wayne H Konetzki, MD (1987–1990): 403 N Grand Ave, Waukesha 53186
Lucille B Glicklich, MD (1987–1990): 3431 N Lake Dr, Milwaukee 53211
Frank H Urban, MD (1987–1990): 10425 West North Ave, Milwaukee 53226
William J Listwan, MD (1987–1990): 279 S 17th Ave, West Bend 53095
Huron L Ericson, MD (1987–1990): 2405 Northwestern Ave, Racine 53404
Marcia J S Richards, MD (1988–1990): 2900 W Oklahoma Ave, Milwaukee 53203

SECOND: Adams, Columbia, Dane, Dodge, Grant, Green, Iowa, Jefferson, Lafayette Marquette, Richland, Rock, Sauk Counties

Sandra L Osborn, MD (1988–1991): 1912 Atwood Ave, Madison 53704
James P Speichinger, MD (1988–1991): 20 S Park St, #450, Madison 53715
James J Tydrich, MD (1988–1991): 1313 W Seminary St, Richland Center 53581
Peter L Eichman, MD (1987–1990): 600 Highland Ave, Madison 53792
Kenneth I Gold, MD (1988–1991): 1905 Huebbe Parkway, Beloit 53511
John D Wegenke, MD (1986–1989): 345 W Washington Ave, Madison 53703

THIRD: Buffalo, Crawford, Jackson, Juneau, La Crosse, Monroe, Trempealeau, Vernon Counties

Pauline M Jackson, MD (1986–1989): 1836 South Ave, La Crosse 54601

FOURTH: Clark, Florence, Forest, Langlade, Lincoln, Marathon, Oneida, Portage, Price, Taylor, Vilas, Wood Counties

William E Raduege, MD (1986–1989): PO Box 549, Woodruff 54568
Robert J Jaeger, MD (1988–1991): 3291 Thompson Court, Stevens Point 54481
Richard H Ulmer, MD (1986–1989): 1000 North Oak Ave, Marshfield 54449

FIFTH: Calumet, Fond du Lac, Green Lake, Outagamie, Waupaca, Waushara, Winnebago Counties

Harry J Zemel, MD (1988–1991): 430 E Division St, Fond du Lac 54935
James L Basiliere, MD (1986–1989): 414 Doctors Court, Oshkosh 54901
Donn D Fuhrmann, MD (1988–1990): 1420 Algoma St, New London 54961

SIXTH: Brown, Door, Kewaunee, Manitowoc, Marinette, Menominee, Oconto, Shawano, Sheboygan Counties

Roger L von Heimburg, MD (1986–1989): 900 S Webster, Green Bay 54301
Joseph C DiRaimondo, MD (1988–1991): 501 N 10th St, Manitowoc 54220
John E Kraus, MD (1986–1989): 1510 Main St, Marinette 54143

SEVENTH: Barron, Chippewa, Dunn, Eau Claire, Pepin, Pierce, Polk, Rusk, St Croix, Burnett, Washburn Counties

Marwood E Wegner, MD (1986–1989): 208 Adams St S, St Croix Falls 54024
Philip J Happe, MD (1988–1991): 733 W Clairemont Ave, Eau Claire 54701

EIGHTH: Ashland, Bayfield, Douglas, Iron, Sawyer Counties

Robert L Sellers, MD (1987–1990): N 28th Street & Hill Ave, Superior 54880

* * *

PRESIDENT: *J D Kabler, MD* (1988–1989), 1552 University Ave, Madison 53705
PRESIDENT-ELECT: *William L Treacy, MD* (1988–1989), 10125 W North Ave, Milwaukee 53226
PAST PRESIDENT: *Kenneth M Viste, Jr, MD* (1988–1989), 100 Stoney Beach Rd, Oshkosh 54901
SPEAKER: *Richard G Roberts, MD* (1987–1989), 777 S Mills Street, Madison 53715
VICE SPEAKER: *Cyril M Hetsko, MD* (1988–1990), 1313 Fish Hatchery Rd, Madison 53715

Ex officio, without vote
Secretary *Adams,* Treasurer *Foley*
Kelli K Heindel, Medical Student, UW–Madison

Delegates to the American Medical Association

DeLore Williams, MD (1988/1989–1990), 8501 W Lincoln Ave, West Allis 53227
Patricia J Stuff, MD (1988/1989–1990), PO Box 366, Bonduel 54107
John K Scott, MD (1988/1989–1990), 20 South Park St, #350, Madison 53715
Richard W Edwards, MD (1987/1988 & 1989), 1313 W Seminary St, Richland Center 53581
John D Riesch, MD (1987/1988 & 1989), PO Box 427, Menomonee Falls 53051
Timothy T Flaherty, MD (1987/1988 & 1989), 547 East Wisconsin Ave, Neenah 54956

Alternate Delegates to the AMA

Cyril M Hetsko, MD (1988/1989–1990), 1313 Fish Hatchery Rd, Madison 53715
John P Mullooly, MD (1988/1989–1990), 8430 W Capitol Dr, Milwaukee 53222
J D Kabler, MD (1987/1988 & 1989), 1552 University Ave, Madison 53706
Kenneth M Viste Jr, MD (1987/1988 & 1989), 100 Stoney Beach Rd, Oshkosh 54901
Richard H Ulmer, MD (1987/1988 & 1989), 1000 N Oak Ave, Marshfield 54449
Jerome W Fons, Jr, MD (1988/1988), 3734 W Coldspring Rd, Greenfield 53221

Young Physicians Section to the AMA

DELEGATE: *Kay E Jewell, MD* (1988–1989), 301 Troy Dr, Madison 53704
ALTERNATE DELEGATE: *T Bayard Frederick, MD* (1987 & 1988), 80 Sheboygan St, Fond du Lac 54935■

*Map indicating location of districts appears on opposite page.

NOTE: Officers, directors, delegates, alternate delegates, and members of commissions and committees are elected at the Annual Meeting (April 1988). Dates in parentheses indicate beginning and expiration of term of office. AMA delegates and alternate delegates' terms of office are on a calendar basis, although elected at the Annual Meeting.

OFFICERS AND DIRECTORS: 1988–1989
State Medical Society of Wisconsin

J D Kabler, MD
Madison

President (1988–1989)

Dr Kabler is a professor of medicine and director of the University Health Service of the University of Wisconsin–Madison. A board-certified specialist in internal medicine with a special interest in the treatment of headache, he is a consultant to the Veteran's Administration Hospital and an active member of the medical staff of University Hospitals in Madison. He was president of the University Hospitals medical staff from 1979 to 1982. Dr Kabler earned his medical degree from the University of Kansas and served his internship and residency at University Hospitals in Madison. He has served as chairman of both the SMS Commission on Governmental Affairs and the Joint Practice Committee. He was a member of the Board of Directors from 1979 to 1987. Dr Kabler has also served as president of the Dane County Medical Society, the Madison Academy of Internal Medicine, and the Wisconsin College Health Association. He is a fellow of the American College of Physicians and a member of the American Psychosomatic Society, the American Association for the Study of Headache, the Society of Military Surgeons and the Society of Medical Consultants to the Armed Forces. He served in the Wisconsin Army National Guard from 1956 to 1974, was chief surgeon from 1967 to 1974, and was decorated with the Legion of Merit.

William L. Treacy, MD
Milwaukee

President Elect (1988–1989)

Dr Treacy graduated from Marquette University School of Medicine in 1957. An internist-rheumatologist, he served an internship at St Joseph's Hospital in Milwaukee and a residency at the Mayo Clinic in Rochester, Minn. Dr Treacy is an active staff member and past chief of the Department of Internal Medicine at St Joseph's Hospital in Milwaukee. He is also an assistant clinical professor at the Medical College of Wisconsin and a past president of the Wisconsin Society of Internal Medicine. He served as a District 1 delegate to the SMS from 1979 to 1988 and was a member of the Physicians Alliance Commission from 1978 to 1981. Dr Treacy has served as chairman of the board of WISPAC since 1983 and as a member of the SMS Medical Liability Committee since 1979.

Thomas L. Adams
Madison

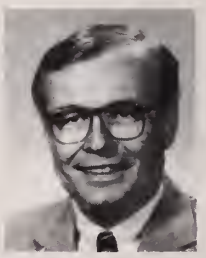
Secretary-General Manager (1988–1989)

Thomas L. Adams was named secretary-general manager of the State Medical Society in March 1987 to succeed its long-time Secretary-General Manager Earl R. Thayer, Madison, who retired at the Society's Annual Meeting in March. Adams was director of the Washington, DC office of the American Society of Anesthesiologists prior to joining the Society in April 1986 as the secretary-general manager designate. Adams formerly served as assistant executive director and lead lobbyist for the North Carolina Medical Society from 1978 until 1983 when he joined the anesthesiology group. Adams graduated from Lenoir Rhyne College in Hickory, North Carolina in 1973. He was born in Albemarle, North Carolina.

John J. Foley, MD
Menomonee Falls

Treasurer (1988–1989)

Dr Foley was reelected treasurer in April 1988 and has served in this position since 1981. He graduated from Stritch School of Medicine in Chicago in 1956 and is assistant clinical professor of surgery at the Medical College of Wisconsin in Milwaukee. Dr Foley served as a director from District 1 from 1972 to 1981. He serves as an ex officio member of the Finance Committee of the Board of Directors and also serves as treasurer of the Board of Directors of SMS Services, Inc.



Kenneth M. Viste, Jr, MD
Oshkosh

Past President (1988–1989)

Dr Viste serves as immediate past president for the 1988–1989 term. A 1966 graduate of Northwestern University Medical School, Dr Viste has been practicing neurology in the Fox River Valley since 1970. He has also been an instructor in

neurology at the Winnebago Mental Health Institute and is an associate clinical professor of neurology at the University of Wisconsin Medical School. He was chairman of the SMS Physicians Alliance Commission from 1978 to 1985 and chairman of the board of directors of WISPAC from 1978 to 1980. He has also been a director of Physicians Insurance Company of Wisconsin. Dr Viste recently was elected to the AMA Council on Legislation.

Richard G. Roberts, MD
Madison

Speaker, House of Delegates (1987–1989)

Dr Roberts was elected Speaker of the House of Delegates in March 1987. Dr Roberts, who graduated from George Washington University Medical School, Washington, DC in 1980, is vice-chairman and member of the Medical Liability Committee, formerly a task force; chairman, ad hoc Committee on Child Abuse and Neglect, now disbanded; and vice-chairman of the Hospital Medical Staff Section. Dr Roberts serves on the American Academy of Family Physicians' Committee on Professional Liability; he is a member of the Wisconsin Academy of Family Physicians' Board of Directors and chairman of its Committee on Professional Liability. He was a family physician practicing in Darlington until he became an assistant professor of Family Medicine at the University of Wisconsin, Madison. He was born in Beaver Dam, Wisconsin.

Cyril M. Hetsko, MD
Madison

Vice Speaker, House of Delegates (1988–1989)

A native of Montclair, NJ, Dr Hetsko graduated from the University of Rochester Medical School in Rochester, NY. He completed an internship and residency at University of Wisconsin Hospitals in Madison and served in the US Army Medical Corps from 1972 to 1975 at the US Army Medical Research Institute of Infectious Disease at Ft Detrick in Frederick, MD. Dr Hetsko is board-certified in internal medicine and is in private practice in Madison. He is chairman of the Department of Medicine at St Mary's Hospital. Dr Hetsko served on the SMS board as a director from District 2 from 1979 to 1988. He has served as an alternate delegate to the AMA since 1983 and is currently chairman of the SMS Task Force on AIDS. He was president of the Wisconsin Society of Internal Medicine in 1987–1988.

Roger L. von Heimburg, MD
Green Bay

Chairman, Board of Directors
Director, District 6

Dr von Heimburg was elected Chairman of the Board of Directors in March 1987. His term on the Board is for the period 1986–1989. He graduated from Johns Hopkins University School of Medicine, Baltimore, Maryland in 1955. His specialty is general surgery. He has been a member of the Board of Directors since 1980; served as vice chairman 1983–1987. He was president of Brown County Medical Society in 1986. Dr von Heimburg is president-elect of the Wisconsin Chapter, American College of Surgeons and is on the Council of the Wisconsin Surgical Society. He was born in Chicago, Illinois.

Richard H. Ulmer, MD
Marshfield

V-Chrmn, Board of Directors
Director, District 4
(1986–1989)

Dr Ulmer was elected to the Board of Directors in 1986. A 1961 graduate of the Stritch School of Medicine of Loyola University, Chicago, he specializes in internal medicine and cardiovascular diseases. He was a member of the House of Delegates' Nominating Committee from 1978–1980, serving as an alternate delegate to the AMA House of Delegates since 1983, and is a member of the Steering Committee of the AMA National Forum for Employed Physicians. He has served as president of the Wood County Medical Society. He was born in Chicago, Illinois.

Huron L. Ericson, MD
Racine

Director, District 1
(1987–1990)

Dr Ericson, whose specialty is orthopedic surgery, was reelected District 1 Director in 1987, having filled the unexpired term of Fredrick Wood, Jr, MD, Kenosha in the 1986–1987 period. Dr Ericson graduated from Northwestern University Medical School, Chicago, in 1965. He served on the ad hoc Committee on Young Physicians prior to establishing the Young Physicians Section to the AMA. He served as president of the Racine County Medical Society in 1982. Dr Ericson was born in Milwaukee, Wisconsin.

Richard H. Strassburger, MD
Milwaukee

Director, District 1

Dr Strassburger received his medical degree from St Louis University in 1953. A specialist in neurosurgery, he served an internship at Milwaukee County Hospital and residencies at Milwaukee County Hospital and the University of Minnesota. Dr Strassburger is a director of the Milwaukee County Medical Society. He was elected as a District 1 delegate to the SMS in April 1988, replacing Jerome W. Fons, MD, of Cudahy.

Donald A. Wollheim, MD
Milwaukee

Director, District 1

Dr Wollheim, a general surgeon, received his medical degree from the Medical College of Wisconsin in 1976. He completed an internship at Saginaw Cooperative Hospitals in Saginaw, Mich, and a residency at St Luke's Hospital in Milwaukee. He has been the chairman of the Public Education Committee of the Medical Society of Milwaukee County for several years and has served on various other committees. Dr Wollheim was elected to a three-year term in April 1988, replacing Glenn H. Franke, MD, of Milwaukee.

Lucille B. Glicklich, MD
Milwaukee

Director, District 1 (1987–1990)

Dr Glicklich was reelected Director in District 1 in March 1987, having first been elected in 1985 to fill the unexpired term of Charles W. Landis, MD. Dr Glicklich, who graduated from the University of Wisconsin Medical School, Madison, in 1950, specializes in child psychiatry and pediatrics. She has been a member of the Commission on Public Information and currently is a member of the Medical Liability Committee (formerly a task force). In 1985 she served as president of The Medical Society of Milwaukee County. Dr Glicklich was born in Fond du Lac, Wisconsin.

Thomas A. Hofbauer, MD
Menomonee Falls

Director, District 1 (1987–1990)

Dr Hofbauer was reelected Director in District 1 in March 1987. Dr Hofbauer, whose specialty is obstetrics and gynecology, graduated from Marquette University School of Medicine (Medical College of Wisconsin) in 1956. He was a member of the Commission on Medical Care Plans when Wisconsin Physicians Service was a division of SMS. He has been a member of the Board of Directors since 1981. He was born in Milwaukee, Wisconsin.

Wayne H. Konetzki, MD
Waukesha

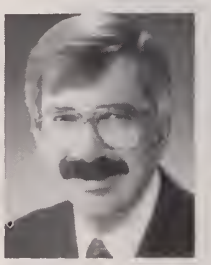
Director, District 1 (1987–1990)

Dr Konetzki was reelected Director, District 1, in March 1987. Dr Konetzki, who specializes in allergy/internal medicine, graduated from the University of Illinois Medical School in 1961. He was first elected to the Board of Directors in 1981. He was born in Chicago, Illinois.

Roger E. Laubenheimer, MD
Milwaukee

Director, District 1 (1986–1989)

Dr Laubenheimer was elected Director, District 1 in 1986. He graduated from the University of Wisconsin Medical School, Madison, in 1950. His specialty is dermatology. He served as a delegate to SMS 1960–1982. He has served on the Board of Directors of The Medical Society of Milwaukee County. He was born in Richfield, Wisconsin.



William J. Listwan, MD
West Bend

Director, District 1 (1987–1990)

Dr Listwan was reelected Director, District 1 in March 1987. He graduated from Marquette University School of Medicine (Medical College of Wisconsin) in 1968 and specializes in internal medicine. Dr Listwan has served as a member of the Physicians Alliance Commission and currently as chairman of the Medical Liability Committee (previously a task force). He has been a member of the Board of Directors since 1984. He was born in Milwaukee, Wisconsin.

Thomas A. Reminga, MD
Milwaukee

Director, District 1
(1986–1989)

Dr Reminga was elected Director, District 1, in April 1986. Dr Reminga, whose specialty is emergency medicine, graduated from the University of Michigan Medical School in 1969. He was a member of the SMS Health Planning Commission (1981–1983) representing the Section on Emergency Medicine. He has served as alternate delegate to SMS since 1979. He was secretary-treasurer of The Medical Society of Milwaukee County in 1983–1984. He was born in Kalamazoo, Michigan.

Marcia J.S. Richards, MD
Milwaukee

Director, District 1

Dr Richards was elected as a District 1 director for a three-year term in April 1988, replacing William L. Treacy, MD, of Milwaukee, who was elected SMS president-elect. Dr Richards graduated from the University of Wisconsin Medical School in Madison and completed both an internship and residency at University Hospitals. A board-certified specialist in therapeutic radiology, Dr Richards is currently director of radiation oncology at St Luke's Medical Center in Milwaukee and is a past president of the Wisconsin Society of Radiation Oncologists. She has been a delegate to the State Medical Society since 1983. Besides serving on the SMS Committee on Cancer, she has been a member and vice chair of the SMS Commission on Health Planning. Dr Richards is currently secretary-treasurer of the Medical Society of Milwaukee County. Dr Richards has also been active in the Wisconsin Division of the American Cancer Society having served as chairperson of the Breast Cancer Detection Awareness Project and as a member of the Board of Directors of that organization.

Frank H. Urban, MD
Wauwatosa

Director, District 1
(1987–1990)

Dr Urban was elected Director, District 1, in March 1987. Dr Urban, whose specialty is dermatology, graduated from the University of Wisconsin Medical School, Madison, in 1954. He is a past delegate and alternate delegate to SMS and currently is on the Membership Committee of the Medical Society of Milwaukee County. He was born in St. Louis, Missouri.

Raymond C. Zastrow, MD
Milwaukee

Director, District 1
(1987–1989)

Dr Zastrow was elected Director, District 1, to fill the unexpired term of H Myron Kauffman, MD. Dr Zastrow, who specializes in clinical pathology and nuclear medicine, graduated from Marquette University School of Medicine (Medical College of Wisconsin) in 1955. He served as chairman and member of the SMS bylaws committee in 1975. He was an alternate delegate to the AMA in 1983–1984. He was appointed to the ad hoc committee of the Health Policy Agenda for the American People (HPA) in 1987. He was born in Milwaukee, Wisconsin.

James P. Speichinger, MD
Madison

Director, District 2

A specialist in obstetrics and gynecology, Dr Speichinger received his degree from the University of Nebraska College of Medicine. He served an internship and residency at the University of Nebraska Medical Center. He is a clinical instructor in the Department of Family Medicine at the University of Wisconsin-Madison. Dr Speichinger has held several offices in the Dane County Medical Society including vice president (1981–1982), secretary-treasurer (1985–1986), president elect (1986–1987), and president (1987–1988). He served as vice chairman of the Department of Obstetrics and Gynecology at St Mary's Medical Center from 1984 to 1986. Elected as a delegate from District 2, Dr Speichinger replaces Cyril M. Hetsko, MD, of Madison.

Peter L. Eichman, MD
Madison

Director, District 2
(1987–1990)

Dr Eichman was elected Director, District 2, in March 1987 for a three-year term, replacing Alwin E. Schultz, MD. Dr Eichman, whose specialties are neurology and internal medicine, graduated from Jefferson Medical College, Philadelphia, Pennsylvania in 1949. He served as Dean of the UW Medical School, 1965–1970, and deputy director, Federal Bureau of Health Manpower Education. He is a member of the Committee on Mental Health. He served as chairman of the Task Force on Physician Review and Discipline and was a member of the Commission on Health Planning, both of which have now been disbanded. He was president of the Dane County Medical Society in 1983–1984. He was born in Philadelphia, Pennsylvania.

Kenneth I. Gold, MD
Beloit

Director, District 2
(1985–1988)

Dr Gold was elected Director, District 2 in 1985. Dr Gold, whose specialty is internal medicine, graduated from State University of New York–Downstate in 1961. He is a member of the Commission on Continuing Medical Education, 1982–1988; a member of the ad hoc Committee on Young Physicians, 1986 to present; and was appointed an Editorial Associate of the *Wisconsin Medical Journal* in March 1987. He was born in New York City.

Sandra L. Osborn, MD
Madison

Director, District 2
(1987–1988)

Dr Osborn was elected Director, District 2 in March 1987 to fill the unexpired term of J D Kabler, MD, president-elect. Dr Osborn, whose specialty is pediatrics, graduated from the University of Wisconsin Medical School, Madison, in 1970. She served as president of the Dane County Medical Society in 1982–1983. She is a member of the SMS Committee on Women Physicians, serving until 1989. She served on the House of Delegates Nominating Committee, the Credentials Committee, and the Reference Committee on Scientific Affairs. She also served on the Ad Hoc Committee on Child Abuse and Neglect. She was born in Durant, Iowa.

James J. Tydrich, MD
Richland Center

Director, District 2
(1985–1988)

Dr Tydrich has been a Director in District 2 since 1981. A 1962 graduate of the University of Wisconsin Medical School, Madison, Dr Tydrich has been a family physician in Richland Center since 1963. He served on the Committee on Cancer 1971–1974, now dissolved. He is serving on the House of Delegates Nominating Committee. He served as president of Richland County Medical Society in 1965 and 1974. He was born in Bloom City, Wisconsin.

John D. Wegenke, MD
Madison

Director, District 2
(1986–1989)

Dr Wegenke was elected in 1986 as a director in District 2. Dr Wegenke, whose specialty is urology, graduated from the University of Wisconsin Medical School, Madison, in 1971. He was born in Berlin, Wisconsin.

Pauline M. Jackson, MD
La Crosse

Director, District 3
(1986–1989)

Dr Jackson has been a Director in District 3 since 1979. A Stanford University Medical School graduate of 1961, Dr Jackson has been practicing psychiatry in Wisconsin since 1972. She is a member of the Committee on Alcoholism and Other Drug Abuse, the Committee on Mental Health, and the Committee on Women Physicians. She also is president of the Wisconsin Psychiatric Association. She was born in Santa Barbara, California.

William E. Raduege, MD
Woodruff

Director, District 4
(1986–1989)

Dr Raduege was elected to the Board of Directors in 1986. Dr Raduege, who is in family practice, graduated from the University of Wisconsin Medical School, Madison, in 1966. He has been a member of the Commission on Mediation and Peer Review since 1981 and delegate from Oneida/Vilas County Medical Society since 1977. He was born in Postville, Iowa.

Robert J. Jaeger, MD
Stevens Point

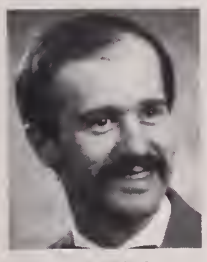
District 4

Elected as a District 4 delegate in April 1988, Dr Jaeger is a specialist in obstetrics and gynecology. He attended the University of Wisconsin Medical School and served an internship and residency at Milwaukee County General Hospital. Dr Jaeger is an assistant clinical professor in the Department of Obstetrics and Gynecology at the Medical College of Wisconsin and serves on the Board of Directors of the University of Wisconsin Medical Alumni Association. He is a member of the SMS Committee on Maternal and Child Health and replaces Jung K. Park, MD, of Wisconsin Rapids on the SMS board.

James L. Basiliere, MD
Oshkosh

Director, District 5
(1986–1989)

Dr Basiliere was elected to the Board of Directors in 1986, succeeding Kenneth M Viste Jr, MD, Oshkosh, who was elected president-elect. Dr Basiliere, whose specialty is internal medicine, graduated from the University of Wisconsin Medical School, Madison in 1962. He was born in Oshkosh, Wisconsin.



Donn D. Fuhrmann, MD
New London

District 5

Dr Fuhrmann was elected a District 5 delegate in April 1988, replacing C. William Freeby, MD, of Appleton. A board-certified family practice specialist, Dr Fuhrmann graduated from the University of Wisconsin Medical School in Madison and served an internship there as well. He served a residency at St Luke's Hospital in Milwaukee. Dr Fuhrmann was chief of the medical staff at the New London Family Medical Center in 1986–1988. Currently an assistant clinical professor at the UW Medical School, Dr Fuhrmann has been secretary of the Waupaca County Medical Society for the past six years.

Harry J. Zemel, MD
Fond du Lac

Director, District 5
(1987–1988)

Dr Zemel was elected to the Board of Directors in March 1987 to fill the unexpired term of Darold A Treffert, MD. Dr Zemel, who graduated from the University of Missouri School of Medicine in 1968, specializes in pathology. He represents the Section on Pathology for the Physicians Alliance Commission. Dr Zemel was president of the Fond du Lac County Medical Society in 1979. He was born in St. Louis, Missouri.

Joseph C. DiRaimondo, MD
Manitowoc

Director, District 6
(1985–1988)

Dr DiRaimondo, a 1965 graduate of Washington University Medical School, St. Louis, Missouri, has served on the Board of Directors since 1985. He serves on the Physicians Alliance Commission. His specialty is orthopedics. He was born in Rockford, Illinois.

John E. Kraus, MD
Marinette

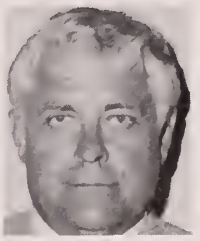
Director, District 6
(1986–1989)

Dr Kraus was elected to the Board of Directors in 1986. Dr Kraus, whose specialty is internal medicine, graduated in 1957 from the University of Buffalo School of Medicine. He was born in Buffalo, New York.

Philip J. Happe, MD
Eau Claire

Director, District 7
(1985–1988)

Dr Happe was elected to the Board of Directors in 1985. Dr Happe, whose specialty is internal medicine, graduated from Creighton University Medical School, Omaha, Nebraska in 1964. He is a past president of the Eau Claire-Dunn-Pepin County Medical Society. He was born in Minneapolis, Minnesota.



Marwood E.Wegner, MD
St Croix Falls

Director, District 7
(1986–1989)

Dr Wegner has been a member of the Board of Directors since 1983. A 1953 graduate of the University of Minnesota School of Medicine, he specializes in family practice. Dr Wegner has served on the Committee on Alcoholism and Other Drug Abuse. He was born in Clear Lake, South Dakota.

Robert L. Sellers, MD
Superior

Director, District 8
(1987–1990)

Dr Sellers was elected to the Board of Directors in March 1987. He is a 1961 graduate of the University of Illinois School of Medicine, and is in family practice. He served as president of the Douglas County Medical Society. He was born in Minneapolis, Minnesota.■

BOARD OF DIRECTORS COMMITTEES: 1988–1989

Executive Committee of the Board
J D Kabler, MD, Madison
Chairman
President of the Society
William L Treacy, MD, Milwaukee
President-elect of the Society
Kenneth M Viste, Jr, MD, Oshkosh
Immediate Past President of the Society
Roger L von Heimburg, MD, Green Bay
Chairman of the Board
Richard H Ulmer, MD, Marshfield
Vice Chairman of the Board
Chairman, Finance Committee
Richard G Roberts, MD, Madison
Speaker of the House of Delegates
Raymond C Zastrow, MD, Milwaukee
Robert L Sellers, MD, Superior
Directors-at-Large
Ex Officio nonvoting members
President and President-elect of SMS Auxiliary

Finance Committee of the Board
Richard H Ulmer, MD, Marshfield, 1989
Chairman
Philip J Happe, MD, Eau Claire, 1991
William J Listwan, MD, West Bend, 1990
Thomas A Reminga, MD, Milwaukee, 1989
Robert L Sellers, MD, Superior, 1990
James J Tydrich, MD, Richland Center, 1991
Harry J Zemel, MD, Fond du Lac, 1991
John J Foley, MD, Menomonee Falls
Treasurer, ex officio

CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION: 1987–1988

(See listing elsewhere in this issue.)■

SMS Services, Inc: 1988

BOARD OF DIRECTORS
William P Crowley Jr MD, Madison, 1989,
President
John P Mullooly MD, Milwaukee, 1990,
Vice President
Thomas L Adams, Madison, 1990,
Secretary
John J Foley MD, Menomonee Falls, 1990,
Treasurer
LeRoy A Johnson, Madison, 1991,
Executive Vice President
Timothy T Flaherty MD, Neenah, 1991
William A Nielsen MD, West Bend, 1991
Jerome W Fons Jr MD, Cudahy, 1989
Allen O Tuftee MD, Beloit, 1989

SPECIAL OFFICER
H B Maroney II, Madison,
Assistant Secretary■

SMS AUXILIARY: 1988–1989

ELECTED OFFICERS
President: Carol Philips, 1410 N Broadway, Marshfield 54449
President Elect: Miep Kempthorne, Route 2, Box 45, Spring Green 53588
Vice President: Christine Frinak, 1032 W Burnett St, Beaver Dam 53916
Secretary: Mary Zastrow, W322 N6853 Wildwood Point Rd, Hartland 53029
Treasurer: Sandra Kontra, 16 N Vincennes Circle, Racine 53402
Immediate Past President: Barbara Newcomer, 2222 Wedgewood Dr, La Crosse 54601

DIRECTORS
Two Years
Gateway: Brenda Reding, 1812 Jackie Rd, Mosinee 54455
Kettle Moraine: Roberta Ortwein, 218 16th St, Racine 53403
Lakeshore: Angela Bell, 313 Cleveland, Manitowoc 54220
North Woods: Patricia Swanson, 1502 W Marshall, Rice Lake 54868
Rib Mountain: Kay Rossman, 3348 N 13th St, Wausau 54401
One Year
Bay: Crystal Sandmire, 201 St Mary's Blvd, Green Bay 54301
Bluff: Eileen Immerman, 403 Third Ave, Eau Claire 54701
Capital: Shafqut Kjan, 1117 Lakeshore Dr, Beaver Dam 53916
Fox Valley: Jean Lawrence, PO Box 1514, Fond du Lac 54935
River: Fe Abellera, 1233 Lauderdale, Onalaska 54650

APPOINTED OFFICERS
Historian: Jacqueline Dungar, 410 W Prospect Ave, Appleton 54911
Parliamentarian: Mary Smigielski, 3351 Poe St, Milwaukee 53215

EXECUTIVE SECRETARY
La Verne Bartel, 330 E Lakeside St, Madison 53715■

PIC-Wisconsin

. . . is not a wholly-owned subsidiary of the State Medical Society; however, officers are elected annually and this list appears elsewhere in this issue as part of the article on PIC-Wisconsin's first year of operation.■

PAST PRESIDENTS OF THE STATE MEDICAL SOCIETY OF WISCONSIN: 1961–1987

This is a partial listing. The complete listing from 1841 to 1972 appeared in the January 1973 issue.

Leif H Lokvam, MD, Kenosha 1961–1962
Nels A Hill, MD, Madison 1962–1963
†William J Egan, MD, Milwaukee 1963–1964
William P Curran, MD, Antigo 1964–1965
†John H Houghton, MD, Wisconsin Dells 1965–1966
†Frank E Drew, MD, Milwaukee 1966–1977
Harold J Kief, MD, Fond du Lac 1967–1968
†William D James, MD, Oconomowoc 1968–1969
Robert E Callan, MD, Milwaukee 1969–1970
†Jerry W McRoberts, MD, Sheboygan 1970–1971
George A Behnke, MD, Kaukauna 1971–1972
Robert F Purtell, MD, Milwaukee 1972–1973
Gerald J Derus, MD, Madison 1973–1974
John E Dettmann, MD, Green Bay 1974–1975
Howard L Correll, MD, Arena 1975–1976
†Charles J Picard, MD, Superior 1976–1977
†Roy B Larsen, MD, Wausau 1977–1978
Jules D Levin, MD, Milwaukee 1978–1979
Darold A Treffert, MD, Fond du Lac 1979–1980
Russell F Lewis, MD, Marshfield 1980–1981
Albert J Motzel Jr, MD, Waukesha 1981–1982
Gerald C Kempthorne, MD, Spring Green 1982–1983
Chesley P Erwin, MD, Milwaukee 1983–1984
Timothy T Flaherty, MD, Neenah 1984–1985
John K Scott, MD, Madison 1985–1986
John P Mullooly, MD, Milwaukee 1986–1987
Kenneth M Viste, Jr, MD, Oshkosh 1987–1988

†Deceased
■

COMMISSIONS AND COMMITTEES: 1988–1989

STATE MEDICAL SOCIETY OF WISCONSIN
330 East Lakeside St (PO Box 1109), Madison, Wisconsin 53701
Telephone: 608/257-6781 (toll-free in Wisconsin 1-800-362-9080)

COMMISSIONS

Continuing Medical Education

This commission shall consist of up to 20 appointed members and the deans of the two medical schools in Wisconsin, or their designees, with vote. It shall be responsible for all matters relating to the whole continuum of medical education, i.e., medical school and residency training as well as lifetime medical learning (continuing medical education). In addition, it shall be responsible for liaison with the medical schools in Wisconsin, their students, residents, fellows and departments of continuing medical education; liaison with specialty societies in the achievement of these goals; liaison with the Commission on Mediation and Peer Review and the Ad Hoc Committee on Health Planning for purposes of implementing continuing medical education programs related to responsibilities and activities of these two groups; and the scientific program of the Annual Meeting. It shall be responsible for accreditation of continuing medical education in hospitals and other institutions or organizations within the state, but shall not be responsible for accreditation of continued medical education within the state's medical schools.

Dianne L Zwicke, MD, Milwaukee, 1991
C William Freeby, MD, Appleton, 1991
Kenneth I Gold, MD, Beloit, 1988, Chrmn
Fred A Melms, Jr, MD, Madison, 1991
Charles E Fenlon, MD, Appleton, 1991
Walter J Vallejo, MD, La Crosse, 1990
Thomas L Zurbriggen, MD, Onalaska, 1991
J David Lewis, MD, West Bend, 1989
Joseph J Mazza, MD, Marshfield, 1989, V-Chrmn
Kathy P Belgea, MD, Wausau, 1989
Victor S Ejercito, MD, Marshfield, 1989
Lori Lynn Neumann, MD, Darlington, 1989
William M Toyama, MD, Marshfield, 1989
John W Beasley, MD, Madison, 1990
Charles E Holmburg, MD, Waukesha, 1990
Edward Zupanc, MD, Monroe, 1990
George Nemec Jr, MD, Woodruff, 1990
Benson L Richardson, MD, Green Bay, 1990

Medical School Deans' designees:
Thomas C Meyer, MD, UW-Madison
Willard Duff, PhD, Medical College of Wisconsin

Subcommittee on Accreditation

Bradley G Garber, MD, Osseo, Chrmn
William Card, MD, Madison
John A Palese, MD, Milwaukee
Melvin F Huth, MD, (Emeritus), Baraboo
Warren J Holtey, MD, Marshfield
Joseph J Mazza, MD, Marshfield
Jerold J Beerends, MD, West Bend
Eugene Musser, MD, Madison
Arnold Effron, MD, Oconomowoc
Richard D Sautter, MD, Marshfield
Philip H Utz, MD, La Crosse
Edward F Banaszak, MD, Milwaukee

STAFF SUPPORT: Division of Scientific and Information Services

Mediation and Peer Review

This commission shall receive, investigate, and seek to resolve differences between physicians and patients or other complainants, or between physicians, on matters relating to quality of care, professional ethics, and fees. When necessary, it shall initiate disciplinary or other action as appropriate. It shall serve as the Society's advisory body to private or governmental organizations on matters affecting medical peer review including utilization review, appropriateness of care, fees, and quality assurance. It shall advise and consult with component societies on issues of peer review, mediation, ethics, and discipline in concert with members of the Board of Directors. It shall serve as the initial appellate body for peer review and mediation issues that are appealed from local committees of component societies. It shall coordinate the impaired physician program.

Albert H Adams, MD, Milwaukee, 1991
Domenick S Bruno, MD, Milwaukee, 1991
George A Pagels, MD, Marshfield, 1991
Charles S Geiger Jr, MD, West Bend, 1991, Chrmn
Dorothy V Skye, MD, Rhinelander, 1991
William V Dovenbarger, MD, Marshfield, 1991
James P Long, MD, Beloit, 1991
Margaret V Nelson, MD, Madison, 1991
John Wm Faber, MD, Neenah, 1989
James E Gutenberger, MD, Madison, 1989
David R LeCloux, MD, Racine, 1989
Joseph R Wilczynski, MD, Racine, 1989
Robert T Cooney, MD, Portage, 1989
Frederick W Blancke, MD, Madison, 1989
Lyle L Olson, MD, Darlington, 1989
Robert E Phillips, MD, Marshfield, 1990
William E Raduege, MD, Woodruff, 1990
Richard C Zimmerman, MD, Menomonee Falls, 1990, V-Chrmn
Michael J O'Neill, MD, Green Bay, 1990
Gay R Anderson, MD, Neenah, 1990
Philip J Dougherty, MD, Menomonee Falls, 1990
Santiago Yllas, MD, Racine, 1990
Virgil L Sharp, DO, Waterloo, representing the Wisconsin Association of Osteopathic Physicians and Surgeons

Coordinating Council on Physician Impairment

Gerald C Kempthorne, MD, Spring Green
Roland E Herrington, MD, Milwaukee
Arthur G Norris, MD, Milwaukee (State Medical Society)
Ms Gwen Jackson, Milwaukee
Joseph L Ousley, MD, Marshfield
Arlen R Delp, DO, New Berlin (Medical Examining Board)

Managing Committee, Statewide Impaired Physician Program

Roland E Herrington, MD, Milwaukee
Gerald C Kempthorne, MD, Spring Green
Fred H Koenecke Jr, MD, Madison
Arthur G Norris, MD, Milwaukee
Michael M Miller, MD, Eau Claire

Medicaid Medical Audit Committee

R Marshall Colburn, MD, Oregon
John A DeGiovanni, MD, Prairie du Sac
Richard W Edwards, MD, Richland Center
Charles S Geiger Jr, MD, West Bend
Leo R Grinney, MD, Racine
John P Hartwick, MD, Milwaukee
Gerald C Kempthorne, MD, Spring Green
John J Kief, MD, Rhinelander
D Mark Lochner, MD, Waupaca
Virgil L Sharp, DO, Waterloo
G John Weir Jr, MD, Marshfield
Alfred D Dally, MD, Madison

STAFF SUPPORT: OFFICE OF CORPORATE COUNSEL

Physicians Alliance

This commission shall plan, organize, and implement programs to protect and preserve the legislative, socioeconomic, and political interests of the members of the State Medical Society of Wisconsin. The commission shall analyze state and federal legislation and administrative rules and policies, and recommend to the Board of Directors specific actions and positions designed to carry out this responsibility. The commission shall also inform the membership of the Society regarding proposed legislation and other public policy initiatives, seek the enactment of legislation for the best interests of the public, scientific medicine, and the medical profession, and promote and encourage Society members to be politically active individually and collectively. This commission shall act to protect the socioeconomic interests of the Society membership in public and private health care delivery systems and recommend to the Board of Directors specific strategies and efforts to achieve this purpose. This commission shall consist of members appointed by the Board of Directors in a number deemed sufficient to execute the responsibilities delegated to the commission. Membership on the commission shall also include a representative from each of the specialty sections of the Society, subject to approval by the Board of Directors. These representatives shall be appointed by the sections annually, and shall have the right to vote on all matters before the commission. The President, President-elect, Immediate Past President, and Chairman of the Board of the Society shall serve as ex-officio members of the commission with vote.

John C Oujiri, MD, Ashland, 1991
Peter J Parthum, MD, MPH, Muskego, 1991
Michael C Reineck, MD, West Bend, 1991
C Peter Erskine, MD, Madison, 1991
Bruce A Kraus, MD, Columbus, 1991
Charles L Steidinger, MD, Platteville, 1991
Miguel T Galang Jr, MD, Milwaukee, 1991
Robert F Purtell Jr, MD, Milwaukee, 1989, Chrmn

continued next page

Expiration of term at Annual Meeting of the year designated appears following member's name. Chairmen and vice chairmen of commissions and committees are elected at the first meeting following the Annual Meeting; therefore, most of the chairmen and vice chairmen listed here are subject to change. The BLUE BOOK is prepared prior to most of these elections; therefore, some commissions and committees will not include these designations.

COMMISSIONS continued

PHYSICIANS ALLIANCE continued

Carl S Eisenberg, MD, Milwaukee, 1989
Raymond C Zastrow, MD, Milwaukee, 1989
Jack M Lockhart, MD, La Crosse, 1989
Michael P Mehr, MD, Marshfield, 1989, V-Chrmn
Christina C Keppel, MD, Milwaukee, 1991
James P Ketterhagen, MD, Wauwatosa, 1989
Bernard F Micke, MD, Madison, 1989
Joseph C DiRaimondo, MD, Manitowoc, 1990
Vernon Dodson, MD, Madison, 1990
Gerald A Gehl, MD, Neenah, 1990
Ronald L Harms, MD, Shawano, 1990
C Robert Jackson, MD, Madison, 1990
Dennis J Kontra, MD, Racine, 1990
DeLore Williams, MD, West Allis, 1990
Timothy G McAvoy, MD, Waukesha, 1990
Paul Grege, Medical Student, MCW
Mark A Weiner, Medical Student, UW

President: *J D Kabler, MD,* Madison
President-elect: *William L Treacy, MD,* Milwaukee
Immediate Past President: *Kenneth M Viste, Jr, MD,* Oshkosh
Chairman of the Board: *Roger L von Heimburg, MD,* Green Bay

SECTION REPRESENTATIVES:

Allergy Section: *Robert J Kriz, MD,* Madison
Anesthesiology Section: *John F Kreul, MD,* Madison
Dermatology Section: *Carla A Skibba, MD,* Hales Corners
Emergency Medicine Section: *C Peter Erskine, MD,* Madison
Family Physicians Section: *Jack Strong, MD,* Mauston
Internal Medicine Section: *Susan L Turney, MD,* Marshfield
Neurology Section: *Gamber F Tegtmeyer Jr, MD,* Madison
Neurosurgery Section: *S Marshall Cushman, MD,* Racine; *Mohammed Rafiullah, MD,* Racine
Ophthalmology Section: *M Thomas Chemotti, MD,* Cedarburg
Otolaryngology Section: *William W Finch, MD,* Madison
Pathology Section: *Harry J Zemel, MD,* Fond du Lac
Pediatrics Section: *Ordean L Torstenson, MD,* Madison
Physical Medicine & Rehabilitation Section: *Donna D Davidoff, MD,* Mequon
Preventive Medicine Section: *Constantine Panagis, MD,* Milwaukee
Radiology Section: *George F Roggensack, MD,* Madison
Resident Physicians Section: *Thomas J Valente, MD,* Milwaukee
Surgery Section: *Robert S Monk, MD,* Waukesha
(Other Section Representatives to be appointed)

Federal Legislation (subcommittee)

Carl S Eisenberg, MD, Milwaukee
Robert L Johnson, MD, Wisconsin Rapids
Roland R Liebenow, MD, Lake Mills
Michael P Mehr, MD, Marshfield
Carl F Myers, MD, Racine
Albert Popp, MD, Milwaukee
Robert F Purtell Jr, MD, Milwaukee
David R Weber, MD, Fond du Lac
Albert L Wiley Jr, MD, Stoughton
DeLore Williams, MD, West Allis
Raymond C Zastrow, MD, Milwaukee
Kenneth M Viste Jr, MD, Oshkosh

STAFF SUPPORT: Division of Public Affairs and Division of Medical Policy and Practice

Public Information

This commission shall be concerned about the members of this Society and their image with the public. It shall plan and execute programs of effective public information and health education, assist component societies in the conduct of similar programs, develop effective media relations.

William H Annesley Jr, MD, Milwaukee, 1991
Benjamin C Wedro, MD, La Crosse, 1991
Jefferson F Ray III, MD, Marshfield, 1991
Irwin J Bruhn, MD, Walworth, 1989, Chrmn
Alan H Cherkasky, MD, Kaukauna, 1989
Timothy T Flaherty, MD, Neenah, 1989
George L Gay, MD, Cambridge, 1989, V-Chrmn
Fred Bartizal Jr, MD, Neenah, 1990
Michael K Augustson, MD, Beaver Dam, 1990
Arthur G Barbier, MD, La Crosse, 1990
Paul D Nelson, MD, Ripon, 1990
Robert R Stumpf, Medical Student, MCW
Jean Lawrence, Fond du Lac, Auxiliary

STAFF SUPPORT: Division of Communications

Wisconsin Medical Journal

The *Wisconsin Medical Journal* shall be the official journal of the Society. An editorial board consisting of the medical editor as chairman and six additional members shall be responsible for all scientific, editorial, and business affairs of the Journal. An editorial director, serving as chairman of a group of no less than five editorial associates, shall be responsible for regularly providing items of editorial opinion for publication in the editorial pages of the Journal.

George W Kindschi, MD, Monroe, 1991
Andrew B Crummy Jr, MD, Madison, 1991
Richard D Sautter, MD, Marshfield, 1989, Chairman and Medical Editor
Dean M Connors, MD, Madison, 1989
Melvin F Huth, MD, Baraboo, 1989
Thomas H Cogbill, MD, La Crosse, 1990
Fredric L Hildebrand, MD, Neenah, 1990
Garrett A Cooper, MD, Madison, Emeritus
Victor S Falk, MD, Edgerton, Emeritus Medical Editor

Editorial Associates

(appointed annually by Board of Directors)

Wayne J Boulanger, MD, Milwaukee Chairman and Editorial Director
Richard D Sautter, MD, Marshfield
Victor S Falk, MD, Edgerton
Russell F Lewis, MD, Marshfield
Kenneth I Gold, MD, Beloit
Jeffrey H Lamont, MD, Wausau
John P Mullooly, MD, Milwaukee
John D Wegenke, MD, Madison

STAFF SUPPORT: Division of Communications

COMMITTEES

Aging, Extended Care Facilities, and Home Health Care

This committee shall be concerned about the process of aging and means to achieve the best possible health care for the aged, including nursing home care and home care.

Roland R Liebenow, MD, Lake Mills, 1991
Edward O Lukasek, MD, Sparta, 1991
James R Damos, MD, Reedsburg, 1991
Paul E Hankwitz, MD, Milwaukee, 1991
Kay E Jewell, MD, Madison, 1989, Chrmn
Joseph E Powell, MD, New Richmond, 1989
Ricardo M Rustia, MD, Kenosha, 1989
Nunilo L Bugarin, MD, Tomahawk, 1989
William C Nietert, MD, Mosinee, 1989
Robert E Phillips, MD, Marshfield, 1990
Richard J Hendricks, MD, Madison, 1990
Edward R Winga, MD, La Crosse, 1990, V-Chrmn
Thomas H Williams, MD, Mukwonago, 1990
T Bayard Frederick MD, Fond du Lac, 1990
John C Heffelfinger, MD, Watertown, 1990
Kelli K Heindel, Medical Student, UW
Joan Janssen, Mequon, Auxiliary

STAFF SUPPORT: Division of Medical Policy and Practice

Alcoholism and Other Drug Abuse

This committee shall be concerned about prevention, treatment, and rehabilitation for persons affected by alcoholism and any other type of drug abuse.

John R Gladieux, MD, Milwaukee, 1991
David L Nelson, MD, Stoughton, 1991
Charles Goodell, MD, Tomahawk, 1991
David Benzer, DO, Wauwatosa, 1991, Chrmn
Edward O Lukasek, MD, Sparta, 1991
Edward J Johnson, MD, Green Bay, 1991
Pauline M Jackson, MD, La Crosse, 1989
David R Downs, MD, Dodgeville, 1989
David D Darcy, MD, Marinette, 1989
Samuel R McCreadie, MD, Milwaukee, 1989
Michael J Logan, MD, Waukesha, 1989
Herbert White, DO, Genesee Depot, 1990
Nunilo L Bugarin, MD, Tomahawk, 1990
Daniel S Thearle, MD, Neenah, 1990
Harry M McCormick, MD, Madison, 1990
Ashok R Bedi, MD, Milwaukee, 1990
Sherry Stormo, Fond du Lac, Auxiliary

STAFF SUPPORT: Office of General Administration

Environmental and Occupational Health

This committee shall be concerned with the health and safety of persons in relation to their environment, including matters relating to occupational and rural health.

Vernon N Dodson, MD, Madison, 1991
Larry A Lindesmith, MD, La Crosse, 1991
Charles W Fishburn, MD, New Berlin, 1991
Samuel Idarraga, MD, Marshfield, 1989
Paul F Durkee, MD, Janesville, 1991
James T Paloucek, MD, Milwaukee, 1991
Charles A Capasso, MD, Neenah, 1991
Melvin S Blumenthal, MD, Monroe, 1989, Chrmn

continued next page

COMMITTEES continued

ENVIRONMENTAL/OCCUPATIONAL HEALTH continued

Robert W Page, MD, Marshfield, 1989
Wendelin W Schaefer, MD, Sheboygan, 1989
Carl Zenz, MD, West Allis, 1989
William W Greaves, MD, Milwaukee, 1989
Albert L Wiley Jr, MD, Madison, 1990
J Steven Moore, MD, Milwaukee, 1990
Henry A Anderson III, MD, Madison, 1990, V-Chrmn
John J Beck, MD, Sturgeon Bay, 1990
Erwin S Huston, MD, Milwaukee, 1990
John T Schmitz, MD, Milwaukee, 1990
Raymond R Johnson, MD, Milwaukee, 1990
Kurt Hegmann, Medical Student, MCW, Milwaukee, 1989
Mrs W W (Jame) Schaefer, Sheboygan, Auxiliary

STAFF SUPPORT: Division of Medical Policy and Practice

Health Care Quality, Costs and Utilization

This committee shall be concerned with promoting an ongoing dialogue with business, industry, and labor. As part of this dialogue special emphasis will be placed on issues relating to the rapidly escalating costs of health care.

Albert J Motzel Jr, MD, Waukesha, 1991, V-Chrmn
Raymond R Johnson, MD, Milwaukee, 1991
Ann C Beecher, MD, Mequon, 1991
Richard H Christenson, MD, Milwaukee, 1991
Carleton B Davis Jr, MD, Monroe, 1991
James V Seegers, MD, Elkhorn, 1989
Stephen Hathway, MD, Green Bay, 1989
Warren H Williamson, MD, Racine, 1989
Kermit L Newcomer, MD, La Crosse, 1989
Russell F Lewis, MD, Madison, 1990, Chrmn
William C Miller, MD, Wausau, 1990
Rosanna M Ranieri, MD, Kenosha, 1990
Richard A Ellingstad, MD, Burlington, 1990
Joshua Safer, Medical Student, UW

STAFF SUPPORT: Division of Medical Policy and Practice

Health Policy Agenda for the American People (ad hoc)

The Board of Directors in 1987 authorized formation of an ad hoc committee to study policy initiatives of the Health Policy Agenda for the American People. The committee will review and make recommendations to the Board on such broad areas as public information, basic benefits packages in evaluating insurance plans, and promoting increased funding for biomedical insurance.

This new committee's list of topics to be covered in the Health Policy Agenda appears in this issue on page 96.

Gerald C Kempthorne, MD, Spring Green, Chairman
James P Ketterhagen, MD, Milwaukee
Kermit L Newcomer, MD, La Crosse
Raymond C Zastrow, MD, Milwaukee
Lucille B Glicklich, MD, Milwaukee

STAFF SUPPORT: Division of Medical Policy and Practice

Maternal and Child Health

This committee shall be concerned about all aspects of health in pregnancy, childbirth and children, with special emphasis on the reduction of maternal mortality and the prevention of disease or disability in children.

Charles Hammond, MD, Neenah, 1991
Perry A Henderson, MD, Madison, 1991
John D Kenny, MD, Madison, 1991
Robert J Koontz, MD, Reedsburg, 1989
Joanne Selkurt, MD, Whitehall, 1989, V-Chrmn
John E Inman, MD, Monroe, 1989, Chrmn
Laura Mueller, MD, Racine, 1989
Stephen C Caselton, MD, Marinette, 1989
Gloria M Halverson, MD, Waukesha, 1990
Daniel F Johnson, MD, Eau Claire, 1990
Walter R Schwartz, MD, Wauwatosa, 1990
Robert J Jaeger, MD, Stevens Point, 1990
James A Meyer, MD, Marshfield, 1991
Murray L Katcher, MD, PhD, Madison, 1991
Shellie A Trentlage, Medical Student, MCW
Roberta Baldwin, Watertown, Auxiliary

Study Committee on Maternal Mortality Survey

Gloria M Halverson, MD, Waukesha, Chairman
Perry A Henderson, MD, Madison
Frederick J Hofmeister, MD, Wauwatosa
Stanley A Korducki, MD, Milwaukee
Ronald W Olson, MD, Madison
Herbert F Sandmire, MD, Green Bay
Albert H Stahmer, MD, Wausau
Everett A Beguin, MD, La Crosse
John E Inman, MD, Monroe
Dan F Johnson, MD, Eau Claire
Robert J Jaeger, MD, Stevens Point
Bernard Poeschel, MD, Eau Claire
E Howard Theis, MD, Fond du Lac
Richard C Brown, MD (Emeritus), Eau Claire
James A Meyer, MD, Marshfield
Dorothy Skye, MD, Rhinelander
Dennis Worthington, MD, Milwaukee

STAFF SUPPORT: Division of Medical Policy and Practice

Medical Liability

The purpose of this committee shall be to monitor current liability developments and to examine a series of options and alternatives relative to a long-range solution of the medical liability problems, reporting to the Board of Dirrectors.

J David Lewis, MD, West Bend, 1991
Lucille B Glicklich, MD, Milwaukee, 1991
Thomas M Kidder, MD, Milwaukee, 1991
Michael C Reineck, MD, West Bend, 1991
W Stuart Sykes, MD, Madison, 1988
Charles F Dungar, MD, Appleton, 1989
C Robert Jackson, MD, Madison, 1989
Sidney E Johnson, MD, Marshfield, 1989
Matthew A Meyer, MD, Pewaukee, 1989
Richard G Roberts, MD, Madison, 1989, V-Chrmn
Paul H Steingraeber, MD, La Crosse, 1989
William L Treacy, MD, Milwaukee, 1989
William J Listwan, MD, West Bend, 1990, Chrmn
James J Logan, MD, Mauston, 1990
Herbert F Sandmire, MD, Green Bay, 1990
Douglas G Devan, MD, Kenosha, 1990
Paul A Jacobs, MD, Milwaukee, 1990
Mark Weiner, Medical Student, UW
Ann Shea, DePere, Auxiliary
Edward Zupanc, MD, Monroe, 1990
S Marshall Cushman Jr, MD, Racine, 1991

Patients Compensation Fund/WHCLIP (subcommittee)

Charles W Freeby, MD, Appleton
C Robert Jackson, MD, Madison
Sidney E Johnson, MD, Marshfield
Thomas M Kidder, MD, Milwaukee
Walter D Moritz, MD, Fort Atkinson
Richard G Roberts, MD, Madison
Paul G Spottswood, MD, Kenosha
William L Treacy, MD, Milwaukee

STAFF SUPPORT: Division of Medical Policy and Practice

Medicine, Religion and Ethics

This committee shall be concerned about the medical-spiritual values of healthcare, the bioethical aspects of medical practice, and the development of closer relationships between physicians and clergy to permit discussion of common problems in the total treatment and care of patients.

Arthur R Derse, MD, Milwaukee, 1991
Arthur G Barbier, MD, La Crosse, 1991
James V Seegers, MD, Elkhorn, 1991
John B Weeth, MD, La Crosse, 1991, V-Chrmn
Maureen Murphy, SSM, MD, Wisconsin Dells, 1991
Rodney Sorenson, DO, Marshfield, 1991
Scott S Erickson, MD, Marshfield, 1991
John W Faber, MD, Neenah, 1989
G Daniel Miller, MD, Oconomowoc, 1989
John K Scott, MD, Madison, 1989, Chrmn
Maxwell H S Weingarten, MD, Milwaukee, 1989
Carl R Poley, MD, Green Bay, 1989
Donald P Davis, MD, Milwaukee, 1989
William O Myers, MD, Marshfield, 1990
John C Jordan, MD, Richland Center, 1990
Gilbert J Nock Jr, MD, Milwaukee, 1990
Philip H Utz, MD, La Crosse, 1990
James E Glasser, MD, La Crosse, 1990
John Berkoff, Medical Student, UW
Lila Seager, Stoddard, Auxiliary

STAFF SUPPORT: Division of Medical Policy and Practice

Membership (ad hoc)

This committee shall function as a sounding board for programs, plans, strategies to address expansion of SMS membership, as well as to evaluate membership campaigns and existing SMS programs. It reports to the Board of Directors.

Timothy T Flaherty, MD, Neenah, Chairman
Richard D Fritz, MD, Milwaukee
Allen O Tuftee, MD, Beloit

continued next page

Mental Health

This committee shall be concerned with all aspects of mental health as an equal part of the patient's total well-being.

William W Garitano, MD, Marshfield, 1991
Donald L Feinsilver, MD, Milwaukee, 1991
Bruce C Rhoades, MD, Wausau, 1991
Wess R Vogt, MD, Milwaukee, 1991
Margaret J Seay, MD, Oshkosh, 1989
Barry Blackwell, MD, Milwaukee, 1989
Peter L Eichman, MD, Madison, 1989
Rudolf W Link, MD, Madison, 1989, V-Chrmn
Laurens D Young, MD, Milwaukee, 1989
Beth Walters-Jones, MD, Madison, 1990
Robert D Miller, MD, Madison, 1990
Kevin J Fullin, MD, Kenosha, 1991
Robert B Shapiro, MD, Madison, 1990
Clarence E Moore, MD, Fond du Lac, 1990, Chrmn
Kevin Kallas, Medical Student, MCW
Larry Park, Medical Student, UW
Marla Natoli, La Crosse, Auxiliary

STAFF SUPPORT: Division of Medical Policy and Practice

Safe Transportation

This committee shall be concerned about the health and safety of all who may be affected by the use of vehicles of transportation on land, water, or in the air.

Stephen W Hargarten, MD, Milwaukee, 1991
Susan Kinast-Porter, MD, Monroe, 1991
James M Huffer, MD, Madison, 1989
John C Heffelfinger, MD, Watertown, 1989
Edward J Johnson, MD, Green Bay, 1989
Richard D Lindgren, MD, Madison, 1989
Thomas J Luetzow, MD, Larsen, 1989
Kathryn P Nichol, MD, Madison, 1990
James L Weygandt, MD, Kohler, 1990, Chrmn
Mrs Donald A (Audrey) Peterson, Madison, Auxiliary

STAFF SUPPORT: Office of General Administration

School Health

This committee shall be concerned about maintaining and improving the health of those attending the public or private schools of this state, including matters related to athletics.

Conrad L Andringa, MD, Madison, 1988, Chrmn
Charles H Miller, III, MD, La Crosse, 1991
Louis Ptacek, MD, Marshfield, 1991
James S Janowiak, MD, Merrill, 1988
Roy E Buck, MD, Oshkosh, 1989
Natalie L Gehringer, MD, Menasha, 1989
Patricio F Viernes, MD, Milwaukee, 1989
Carol A Blum, MD, Ashland, 1990
Rolf L Simonson, MD, Sheboygan, 1990
Jeffrey H Lamont, MD, Wausau, 1990
Mrs Kenneth (Mary) Smigielski, Milwaukee, Auxiliary
Mrs K Alan (Sherry) Stormo, Fond du Lac, Auxiliary

WIAA Medical Advisory Committee

James C H Russell, MD, Fort Atkinson, Chrmn
Conrad L Andringa, MD, Madison
James H DeWeerd Jr, MD, Stevens Point
Frederick W Gissal, MD, Wisconsin Rapids
Ronald L Harms, MD, Shawano
Kermit L Newcomer, MD, La Crosse
Elizabeth A Steffen, MD, Racine
Phillips T Bland, MD, Westby

STAFF SUPPORT: Division of Communications

WNA–SMS Liaison

In 1987 the Nurse Physician Liaison Committee was renamed the WNA-SMS Liaison Committee.

This committee shall be concerned with developing recommendations, as appropriate, regarding education, legislation, practice arrangements and delivery patterns; shall facilitate understanding and acceptance by the professions and the public of changing medical and nursing relationships, roles and practices; shall serve as a consultation resource in matters that relate to joint practice.

SMS MEMBERS
Carl S Eisenberg, MD, Milwaukee, 1991
Marc F Hansen, MD, Madison, 1989
Robert T Cooney, MD, Portage, 1989
Albert J Motzel Jr, MD, Waukesha, 1990 Cochairman
Daniel E Britton, MD, Madison, 1990

WNA MEMBERS
Judy Ellington, RN, Baraboo, Chairman
Norma Lang, RN, PhD, Milwaukee
Leona Vandevusse, RN, Milwaukee
Sherry Quamme, RN, Columbus
Susan Bulgrin, RN, Portage

TASK FORCES

Task Force on AIDS

In 1987 the Board of Directors established this task force to advise members of the State Medical Society on the formulation of public policy to address the scientific, medical, ethical, legal, and legislative issues pertaining to AIDS.

SMS MEMBERS
Cyril M Hetsko, MD, Madison, Chrmn
Michael Dailey, MD, Menomonee Falls
Edwin L Overholt, MD, La Crosse
J Douglas Lee, MD, Marshfield
Constantine Panagis, MD, Milwaukee
Peter Parthum, MD, Muskego
Gerald Dorff, MD, Milwaukee
Stephen Hathway, MD, Green Bay
Raymond Bachhuber, MD, Green Bay
Ian Gilson, MD, Milwaukee
Richard Reich, MD, Madison
Kay Jewell, MD, Madison
Patricia Barwig, MD, Milwaukee
Charles Junkerman, MD, Milwaukee
Louise Scott, Madison, Auxiliary

WHA MEMBERS
Harold Brown, Administrator Prairie du Chien Memorial Hospital
Joseph Ross, President Mercy Medical Center, Oshkosh
Diane Ebersberger, WHA, Madison

SPECIAL ADVISORY MEMBERS
Stanley Inhorn, MD, Madison
Jeffrey P Davis, MD, Madison
(***James Vergeront, MD,*** Madison, Alternate)

STAFF SUPPORT: Division of Membership and Communications■

Expense reimbursement policy and procedure for physicians on State Medical Society business

IT IS THE POLICY of the State Medical Society of Wisconsin to offer reimbursement of out-of-pocket expense incurred by its officers, directors, committee chairmen and members, AMA delegates and alternates and other designated physicians when such expense is incurred in the course of the conduct of business on behalf of the Society. The Society recognizes that any such leadership role requires a substantial contribution in personal time on the part of the physician. It is traditional that this be accepted as a contribution to the profession and the health of the public. However, out-of-pocket expenses in the discharge of official functions of the Society are reimbursable as set forth below, except that district directors are not reimbursed for the expense of attending the Annual Meeting of the Society (Bylaws, Chapter V, Sec. 4).

Officers, Directors, Committee Chairmen and Members, and Other Designated Persons

Reimbursable expenses include the cost of:

1. All meals, including normal tips, incurred while away from the physician's home city on SMS business.
2. All meals in the home city of the physician when these are in relation to an SMS business meeting.
3. Entertainment expenses where such expense is clearly a proper and necessary adjunct to the conduct of the physician's business function for the Society.
4. Valet and laundry services when the physician is away from the home city on SMS business continuously for four (4) days or more.
5. Lodging for those days (nights) reasonably associated with the dates of a meeting for which expenses are claimed.
6. Transportation from home city to meeting site and return as follows:

   Air—Cost of round trip coach airfare, plus necessary ground transportation.

   Bus/Train—Cost of round trip fare, plus necessary ground transportation.

   Auto—Mileage at the current Society rate (now 22¢) to and from the meeting site, plus necessary parking fees and highway tolls.

   Miscellaneous Ground Transportation—Local bus and cab fares as necessary.

   Auto Rental—All or some portion of such cost may be reimbursed as a substitute for other ground transport when this is the most feasible alternative following initial air, bus or train travel. Example, remote resort meeting site.
7. Telephone and telegraph communications relative to SMS business.
8. Secretarial and copying services, postage and stationery used for SMS business.

   Note: SMS Headquarters is prepared to handle most official correspondence and reproduction work for officers and committee members. However, physicians may be reimbursed for personal or office costs relating to secretarial, copying, postage and stationery utilized in conducting SMS business.

   Note: Copies of all official correspondence should be sent to the appropriate committee staff person at SMS so as to assure proper coordination and recordkeeping.
9. Expenses, as described in 1-8 above, incurred by the physician's spouse when accompanying him/her in an official capacity or when the spouse is "expected" to be in attendance are reimbursable.

Procedure for Claiming Expenses

1. To obtain reimbursement the physician must submit a statement of expenses incurred.
2. Attach copies of bills or receipts for all lodging, travel, and meals over $25.
3. Itemize separately costs for Item 8 above.
4. Mail to SMS, Attn: Accounting Department, PO Box 1109, Madison, Wis 53701.

Reimbursement will be made within two weeks following receipt and approval of the expense report.

AMA Delegates and Alternates

AMA Delegates and Alternates (including the Young Physicians Section delegate and alternate) from Wisconsin receive reimbursement as follows for each meeting to the AMA House of Delegates they attend:

1. Round trip economy air fare (advance booking strongly suggested.)
2. Actual cost of room (mid-range) for five nights at the Annual Meeting and 4 nights at the Interim Meeting.
3. $60 per day for food and all incidentals for six days at the Annual Meeting and five days at the Interim Meeting.

When such delegates and alternates are conducting SMS business not in conjunction with meetings of the AMA House of Delegates, their expenses may be reimbursed in the same manner as outlined for Officers, Directors, etc.

Out-of-State Trips

With the exception of AMA House of Delegates meetings and travel by the President/President-Elect, all out-of-state trips must have prior approval by the Executive Committee to be reimbursable. Contact the Secretary and General Manager. ■

Approved by Board of Directors, July 18, 1981; Revised Oct 16, 1987.

HOUSE OF DELEGATES: 1988

State Medical Society of Wisconsin

Speaker: Richard G Roberts/Vice Speaker: Vernon M Griffin

County Medical Society	Delegate	Alternate
FIRST DISTRICT		
KENOSHA	Meredith C Clubb	Roman Bilak
	Clifton E Peterson	Ricardo M Rustia
	Paul G Spottswood	Michael J Wempe
MILWAUKEE	Albert H Adams	David G Benzer
	Francis I Andres	Jeffrey R Bond
	William H Annesley Jr	James G Caya
	Patricia M Barwig	Robert P Cronin
	Donald R Beaver	James A Cunningham
	John T Bjork	James D Dolan
	John E Cordes	Ian H Gilson
	Donna D Davidoff	Ronald D Hart
	Donald P Davis	Jeffrey M Jentzen
	Gerald J Dorff	Raymond R Johnson
	Harry R Foerster Jr	Anthony J Linn
	Jerome W Fons Jr	James P Maney Jr
	Peter S Foote	Gilbert J Nock Jr
	Lucille B Glicklich	Peter J Parthum
	Russell S Gonnering	John E Ridley III
	Gerald G Govin	Ali A Sadoughian
	Paul E Hankwitz	Laura A Sunn
	Jacqueline Coates Howell	Burton A Waisbren
	Brian W Kennedy	
	Christina C Keppel	
	James P Ketterhagen	
	Thomas M Kidder	
	Stanley A Korducki	
	Robert F Madden	
	James A Means III	
	Dean D Miller	
	John P Mullooly	
	Robert F Purtell Jr	
	Thomas A Reminga	
	Marcia J S Richards	
	Roger L Ruehl	
	George R Schneider	
	William L Treacy	
	Frank H Urban	
	Wess R Vogt	
	Jeffrey M Weber	
	John E Whitcomb	
	DeLore Williams	
	D Maclean Willson	
	Donald A Wollheim	
	Carol E Young	
	Anthony P Ziebert	
OZAUKEE	Arthur B Conrad	Robert A Pfeffer
RACINE	Marvin G Parker	Victoriano A Baylon
	Kenneth J Pechman	E Paul Gander
	Gregory A Shove	Mitchell H Leavitt
	Raymond E Skupniewicz	Kevin W Mc Cabe
	William H Stone	Vacancy
WALWORTH	Irwin J Bruhn	Edsel G Doreza
WASHINGTON	Charles S Geiger Jr	William J Listwan
	Michael C Reineck	Eric F Weber
WAUKESHA	Michael P Dailey	Brian A Chapman
	Charles E Holmburg	Uriel R Limjoco
	Timothy G Mc Avoy	Kraig E Lorenzen
	G Daniel Miller	Dean L Martinelli
	Michael G O'Mara	John R Park
	John D Riesch	Jay F Schamberg
	James A Stadler II	Gwendolyn Tanel
	Lee M Tyne	Herbert C White

County Medical Society	Delegate	Alternate
SECOND DISTRICT		
COLUMBIA-MARQUETTE-ADAMS	Robert T Cooney	Martin L Janssen
DANE	Raymond W M Chun	S Craighead Alexander
	Peter L Eichman	Thomas H Browning
	Judith N Green	Dolores A Buchler
	Cyril M Hetsko	James E Engeler Jr
	William L Kopp	Eugene S Farley Jr
	Richard D Lindgren	Susan M Haack
	Felipe B Manalo	Kay A Heggestad
	Bradley L Manning	Susan N Isensee
	David L Nelson	Robert A Mc Donald
	Sandra L Osborn	Paul A Mc Leod
	Joseph F Sackett	Willis G Mc Millan
	Robert B Shapiro	Kathryn P Nichol
	Sigurd E Sivertson	Phillip J Schoenbeck
	James P Speichinger	Nancy J Selfridge
	Richard L Staley	Benton C Taylor
	Marc D Tumerman	Walter L Washburn
	Roland J Vega	Richard O Welnick
	John D Wegenke	Ronald D Wenger
	Paul A Wertsch	John E Woodford
DODGE	Edward F Cody	M Ahmad Ali
GRANT	Charles L Steidinger	James R Heersma
GREEN	Melvin S Blumenthal	Vacancy
	Jan E Erlandson	Vacancy
IOWA	Harald P L Breier	Timothy A Correll
JEFFERSON	George L Gay Jr	Arthur S Marquis
LAFAYETTE	Vacancy	Lyle L Olson
RICHLAND	James J Tydrich	Thomas L Richardson
ROCK	Jordan Frank	Ronald K Bowers
	David B Gattuso	Edward C Miller
	James P Long	P Richard Sholl
	Daniel T Peterson	Terrance L Wiseman
SAUK	John A De Giovanni	Donald W Vangor
THIRD DISTRICT		
CRAWFORD	Michael S Garrity	Randall J Kieser
JUNEAU	Leon J Radant	D Keith Ness
LA CROSSE	Thomas P Lathrop	Arthur G Barbier
	Jack M Lockhart	Michael H Mader
	Paul H Steingraeber	James E Novotny
	David E Westgard	Robert S Witte
	Edward R Winga	Vacancy
MONROE	Edward O Lukasek	Kevin A Jessen
TREMPEALEAU-JACKSON-BUFFALO	Jeffrey K Polzin	W Bradford Martin
VERNON	Timothy J Devitt	Mark H Andrew

County Medical Society	Delegate	Alternate
FOURTH DISTRICT		
CLARK	Bahri O Gungor	Reganti V R Reddy
FOREST	Burton S Rathert	E Frank Castaldo
LANGLADE	Michael J Reinardy	James O Moermond Jr
LINCOLN	James S Janowiak	Modesto M Ferrer
MARATHON	Curt G Grauer	Kathy P Belgea
	William R Owen	Joel R De Koning
	J Garry Sack	Thomas O Miller
	Gerald H Schroeder	Vacancy
ONEIDA-VILAS	Paul W Grotenhuis	William E Raduege
	Bruce F Hertel	Vacancy
PORTAGE	Daniel L Brick	Robert J Jaeger
PRICE-TAYLOR	Michael A Haase	William E Yanke
WOOD	Michael J Kryda	Richard W Clasen
	William J Maurer	Louis C Hacker
	Michael P Mehr	Jung Kyun Park
	Robert E Phillips	Mario V Ponce
	Charles C Sorensen	Theodore A Praxel
	John E Thompson	John W Schaller
FIFTH DISTRICT		
CALUMET	William E Hannon	Badri N Ganju
FOND DU LAC	Brian C Christenson	Russell S Pelton
	K Alan Stormo	Elizabeth T Sanfelippo
	David R Weber	Vacancy
GREEN LAKE-WAUSHARA	Barbara L Rosenthal	Jeffrey J Carroll
OUTAGAMIE	Henry Chessin	George A Behnke
	Charles F Dungar	Vacancy
	David R Finch	Vacancy
	C William Freeby	Vacancy
WAUPACA	Joseph W Weber	Lloyd P Maasch
WINNEBAGO	George W Arndt	Edwin L Downing
	James L Basiliere	Owen L Felton
	John E Hoggatt	Gerald A Gehl
	Eric B Wilson	Johan A Mathison
	Vacancy	Vacancy
SIXTH DISTRICT		
BROWN	Thomas P Koehler	Patrick M Carrigan
	Rolf S Lulloff	James T Jerzak
	Carl R Poley	Kenneth M Kubsch
	Herbert F Sandmire	Michael G Mc Henry
	Ronald G Thune	Roderick L Meves
	David M Wineinger	Vacancy
DOOR-KEWAUNEE	John J Beck	Mark O Weisse
MANITOWOC	Edward J Barylak	Joseph E Trader
	Norman J Schroeder II	Vacancy
MARINETTE-FLORENCE	Dean A Magnin	John E Kraus
OCONTO	James J Wallace	Glen J Heinzl
SHAWANO	Ronald L Harms	Miguel-Angel Jimenez
SHEBOYGAN	Robert A Keller	Robert A Helminiak
	Vytas K Kerpe	Roger G Klettke
	Mark W Sharon	James R Pawlak

County Medical Society	Delegate	Alternate
SEVENTH DISTRICT		
BARRON-WASHBURN		
BURNETT	James F Maser	Donald E Riemer
	Roger F Macy	William A Smith
CHIPPEWA	Merne W Asplund	Peter W Holm
EAU CLAIRE-DUNN-PEPIN	Robert Burgfechtel	Edgar O Hicks
	C Thomas Dow	Stanley G Norman
	Michael F Finkel	Vacancy
	Daniel F Johnson	Vacancy
PIERCE-ST. CROIX	Joseph E Powell	James R Beix
POLK	John O Simenstad	William W Young
RUSK	Howard T Chatterton	Douglas M De Long
EIGHTH DISTRICT		
ASHLAND-BAYFIELD-IRON	Charles R Longstreth	John C Oujiri
DOUGLAS	Clarence M Scott	Vacancy
SAWYER	Lloyd M Baertsch	Paul Strapon III

SECTIONS	Delegate	Alternate
Allergy & Clinical Immunology	Marshall E Cusic	Robert J Kriz
Anesthesiology	Warren J Holtey	John H Barsch
Cardiology	D Joe Freeman	Robert M Green
Dermatology	Joel E Taxman	Nyles R Eskritt
Emergency Medicine	Thomas J Luetzow	Jonathan Robinson
Family Physicians	Robert S Viel	Thomas H Peterson
Hospital Medical Staff	Stephen R Peters	Louis R Pfeiffer
Internal Medicine	Les Harrison	Susan L Turney
Medical Faculties	Mark J Ciccantelli	Manucher J Javid
Medical Students	Jonathan H Berkoff	Vacancy
Neurology	R Clarke Danforth	Gamber F Tegtmeyer Jr
Neurosurgery	Glenn A Meyer	S Marshall Cushman Jr
Obstetrics-Gynecology	Charles Hammond	Michael A Schellpfeffer
Ophthalmology	M Thomas Chemotti	Gregory P Kwasny
Orthopedics	James A Rydlewicz	James Langenkamp
Otolaryngology	Glenn M Seager	Thomas W Grossman
Pathology	Raymond C Zastrow	Ronald R Martins
Pediatrics	Carl S L Eisenberg	Vacancy
Physical Medicine & Rehabilitation	William J La Joie	Ram Parvesh Bhala
Plastic Surgery	Sharon L Elias	Terrence J Wilkins
Preventive Medicine	Constantine Panagis	Jane A Kilsdonk
Psychiatry	Rudolf W Link	Vacancy
Radiation Oncology	Robert H Greenlaw	Sally M Schlise
Radiology	Vacancy	Robert E Durnin
Resident Physicians	Vacancy	Vacancy
Surgery	Louis C Bernhardt	Dean B Pratt
Urology	Stuart W Fine	Charles W Troup
Young Physicians	Bruce A Kraus	Laura J Mueller

House of Delegates actions

The House of Delegates considered 38 resolutions and a number of reports from officers, directors, committees and commissions, and a summary of the House's actions follows. The resolutions and reports were widely distributed to delegates, alternates and county medical society officers, and abstracts of the resolutions were published in the March 1988 issue of the *Wisconsin Medical Journal.*

Members of the Society may, upon request, study the official transcript of the meeting at the SMS headquarters in Madison, or receive a copy of the full contents of particular reports or resolutions.

Reference Committee on Socioeconomic Activities

Report B of the Physicians Alliance Commission outlined the efforts of the commission over the past year and Capitol Update, an addendum to the report, provided a wrap up of government action on issues of concern to SMS. ***Action:*** adopted.

Report K of the Committee on Mental Health described the efforts made toward eliminating unwarranted prejudice against mental illness and improving the delivery of care. ***Action:*** adopted.

Report O of the Medical Liability Committee outlined the committee's work on a broad range of issues related to medical liability. ***Action:*** adopted.

Resolution 6 proposed that the required purchase of tail coverage be waived by the Physicians Insurance Company of Wisconsin (PIC-Wisconsin) for physicians who maintain professional liability insurance for five years or longer. ***Action:*** rejected.

Resolution 9 recommended that SMS give high priority to pursuing the enactment limit of $250,000 on noneconomic damages in medical professional liability cases and the repeal of the 1990 sunset on the current limit. The committee recommended the following amendment: "Resolved, that the State Medical Society continue to give high priority during the 1989 Wisconsin Legislature for the enactment of legislation that 1) will limit total recovery for noneconomic damages in medical malpractice lawsuits to $250,000 for both awards and settlements, and 2) will repeal the current sunset of December 31, 1990, on the existing noneconomic damages cap for medical liability awards." ***Action:*** adopted as amended.

Resolution 16 urged the placement of a practicing pathologist or other clinical laboratory representative on the Board of the State Laboratory of Hygiene. ***Action:*** referred to the SMS Board of Directors for assignment to an appropriate committee and further study.

Resolution 19 dealt with risk management courses offered by PIC-Wisconsin and other medical liability insurers. The committee recommended the following amendment: "Resolved, that PIC-Wisconsin and other medical liability insurance companies be encouraged to develop courses of instruction and other resources on medical professional liability risk management." ***Action:*** adopted as amended.

Resolution 20 directed the SMS to form physician support groups throughout the state. The committee recommended the following amendment: "Resolved, that the State Medical Society continue to publicize the availability of the physician support program to the membership on a regular basis, and make the program available to physicians who are threatened with malpractice suits as well as those who have been formally named in a suit." ***Action:*** adopted as amended.

Resolution 21 called for an actuarial study and listing, based on cost savings, of possible reforms in the laws governing medical professional liability. ***Action:*** rejected.

Resolution 22 called for the SMS to file a lawsuit challenging the statutory requirement that all physicians carry unlimited liability coverage via the Patients Compensation Fund. ***Action:*** rejected.

Resolution 23 called for the SMS to support increases in charges to attorneys for records, physicians' depositions, and physicians' testimony. ***Action:*** rejected.

Resolution 24 called for a change in financing of the Patients Compensation Fund and medical professional liability insurance companies whereby judgments and settlements would be paid out of current reserves until those funds are expended, and subsequently yearly premiums would be set at a level equal to yearly payout. ***Action:*** rejected.

Resolution 25 sought to require medical professional liability defense attorneys to agree to pursue legal action against plaintiff's attorneys in frivolous cases. ***Action:*** rejected.

Resolution 26 called for an investigation and redefinition of procedures for facility inspections, citations for violations, and other actions by the Bureau of Quality Compliance of the Department of Health and Social Services. ***Action:*** referred to the Board of Directors for further study.

Resolution 29 called on the SMS to develop a uniform definition for experimental therapies and procedures, and to establish a central information clearinghouse. ***Action:*** referred to the SMS Board of Directors, for possible reformulation and submission to the AMA House of Delegates.

Resolution 32 sought to facilitate

the issuance of temporary parking permits for the disabled. The committee recommended the following amendment: "Resolved, that the State Medical Society facilitate an alteration in state statute or administrative code to assure the temporary issuance of disabled permits in a patient's home locality on a timely basis." ***Action:*** adopted as amended.

Resolution 34 urged support for legislatively mandated insurance coverage for investigation and treatment of infertility problems. ***Action:*** rejected.

Resolution 37 urges the SMS to continue seeking state funding for vaccine purchases in the Wisconsin Immunization Program, thereby enabling local public health departments to provide immunizations to those in need. The committee recommended deleting a second "resolved" clause which would have sent copies of the resolution to the governor and all legislators. ***Action:*** adopted as amended.

Resolution 38 recommended that the SMS call for physicians who advertise a specialty for which they are not board-certified to include a disclaimer in their ads. ***Action:*** rejected.

Reference Committee on Organization and Finance

Resolution 2 called for the SMS to study physician needs for contract review and negotiation services and to provide such services if warranted. The committee offered a substitute resolution: "Resolved, the Young Physicians Section meet with SMS staff to study the mechanism for physician contract review and disseminate its findings to young physician members." ***Action:*** adopted as amended.

Resolution 3 was amended by the committee to read: "Resolved, that the SMS develop an informational publication to help physicians select a malpractice carrier, and it be distributed to SMS members, including medical students and residents upon request." ***Action:*** adopted as amended.

Resolution 27 urged SMS to hold a portion of its meetings in the northern half of the state. ***Action:*** rejected.

Resolution 35 proposed a constitutional change in the election of the president elect. ***Action:*** held over until the 1989 Annual Meeting, as required by SMS Bylaws.

Report D Commission on Public Information, with informational reports on Wisconsin Physicians Political Action Committee; Charitable, Educational and Scientific Foundation; AIDS Task Force; and SMS Services, Inc. ***Action:*** filed.

Report Q recommended a strategic plan for the SMS, a dues increase of $15 for 1989, an expanded Impaired Physician Program funded by an additional $15 dues increase, and the following Bylaws change: "Chapter I, Section 10 C. Physicians in residency or fellowship training: dues and assessments to be determined by the Board of Directors." ***Action:*** adopted.

Treasurer's report: The committee noted the presence of tobacco stock on the list of SMS investments and recommended that, in the future, the SMS General Fund investment portfolio not include stock or bonds of companies that generate a significant amount of their revenues from the production of tobacco products. ***Action:*** received.

Reference Committee on Scientific Activities

Resolution 4 recommended establishment of procedures for the release of medical information to assure confidentiality while allowing timely exchanges of information for insurance and review purposes. The committee recommended deletion of the words "work with the insurance commissioner to." ***Action:*** adopted as amended.

Resolution 5 requested support for legislation to prohibit high speed pursuits of traffic law violators by law enforcement officials. ***Action:*** referred to the Committee on Safe Transportation for further study.

Resolution 7 recommended that the Society endorse the Advance Trauma Life Support course sponsored by the Committee on Trauma of the American College of Surgeons and to encourage physicians involved in emergency care to take the course. ***Action:*** rejected.

Resolution 11 recommended support for legislation requiring restaurants to specify on the menu when alcohol is used in the preparation of food. ***Action:*** rejected.

Resolution 15 advocated a routine, voluntary HIV-antibody test for prospective surgical patients, and requested that test results be considered when determining the appropriateness of surgery, and further, that the patient's antibody status and the safety of health care workers be considered in the treatment plan. ***Action:*** rejected.

Resolution 17 requested endorsement of the concept of teacher/National Athletic Trainers Association-certified trainers for Wisconsin high schools. The committee recommended deletion on line 34 of "5 to" and the addition of the following clause: "Resolved, that athletic trainers would serve on site in association with volunteer team physicians." ***Action:*** adopted as amended.

Resolution 28 supported the voluntary physician-patient relationship, which includes the right of either the patient or the physician to discontinue the relationship. ***Action:*** rejected.

Resolution 31 recommended the development of "criteria for public safety" at major public events. ***Action:*** adopted and referred to the Board of Directors for implementation.

Resolution 36 called for a task force to investigate the need for categorization of critical care capabilities of Wisconsin hospitals and asked that the state delay adoption of categorization or designation of systems until the task force work is completed. The committee recommended the deletion of the clause: "Resolved, that the Legislature be asked for a clarification of its intent in Statute 146.301 (6)." ***Action:*** adopted as amended.

Report A noted that the SMS Commission on Continuing Medical Education has been awarded four years of full accreditation. The committee also noted the commission's concern over the lack of participation

in the Annual Meeting by a number of medical specialties. ***Action:*** accepted.

Report C reviewed the activities of the Commission on Mediation and Peer Review and its subcommittees. ***Action:*** adopted.

Report E, of the Editorial Board, outlined the scientific and special papers submitted and reported the establishment of a writing contest for medical students and residents. Also reported were the retirements of Dr Victor S. Falk, after 25 years as medical editor, and Managing Editor Mary Angell, after 30 years with the *Wisconsin Medical Journal*. ***Action:*** accepted.

Report F reviewed a number of issues addressed by the Committee on Aging, Extended Care Facilities and Home Health Care. ***Action:*** accepted.

Report G discussed the activities of the Committee on Alcoholism and Other Drug Abuse, and its cooperation with state and other agencies concerned with substance abuse. ***Action:*** accepted.

Report I summarized the activities of the Committee on Maternal and Child Health, noting legislation reviewed and projected programs. ***Action:*** accepted.

Report J noted that, on directive from the SMS Board of Directors, bioethical issues have been the priority for the Committee on Medicine, Religion and Ethics. ***Action:*** accepted.

Report L issued guidelines for drawing blood for chemical testing for law enforcement, revised by the Committee on Safe Transportation. The Reference Committee on Scientific Affairs recommended approval of the guidelines and adoption of a policy statement on medical examination for safety belt usage, which was included in the report, and directed the Society to inform physicians of, and oppose, the sunset date on the seat belt law. ***Action:*** accepted as amended.

Report M requested approval of four recommendations: 1. a slight modification of the committee's original charge, 2. support for the Smoke Free Class of 2000 program, 3. support for the recommendation by the Department of Public Instruction and the Department of Health and Social Services that instruction about AIDS be integrated into health education curricula, and 4. discontinuing scoliosis screening programs in schools. ***Action:*** accepted.

Reference Committee on National Issues

Resolution 1 called for the SMS to continue working with the AMA and HCFA to correct discriminatory practices in the implementation of Maximum Allowable Actual Charges. ***Action:*** adopted.

Resolutions 8 and 33 urged the SMS to work toward correcting the inequities of physician reimbursements under the present Medicare system. ***Action:*** adopted.

Resolution 10 called for the SMS to assume the scientific position that a fertilized ovum is a human embryo and potentially a human being, and for the SMS to support the US Department of Health and Human Services' position that family planning programs receiving federal funds may not provide abortion counseling or referrals and may not engage in lobbying or legal action to increase the availability of abortions. ***Action:*** referred to the Committee on Medicine, Religion and Ethics for further study, with a directive to report to the SMS House of Delegates at the 1989 Annual Meeting.

Resolution 12 asked the SMS to support the development and enforcement of hazardous air emissions rules by the Department of Natural Resources. ***Action:*** adopted.

Resolution 13 was amended by the committee as follows: "Resolved that the State Medical Society of Wisconsin work for the introduction of legislation which would require that all enclosed public places be maintained as totally smoke free environments." ***Action:*** adopted as amended.

Resolution 14 called for the SMS to oppose recent changes in Medicare regulations alleged to encourage surgeons to delegate postoperative care to non-physicians. ***Action:*** referred to the Section on Ophthalmology for review and reconsideration.

Resolution 18 called upon the SMS and AMA to urge Congress and the president to enact comprehensive clean ambient air legislation without further delay. The committee amended the resolution to require copies of the resolution to be sent to the medical societies of states bordering Wisconsin and to the Indiana State Medical Association. ***Action:*** adopted as amended.

Resolution 30 called upon the SMS to define the ethical issues of financial incentives for restricting or limiting access to care in managed health plans. ***Action:*** referred to the Board of Directors for further discussion, with a directive to report to the House of Delegates at the 1989 Annual Meeting.

Report BB reviewed the major issues addressed by the Committee on Federal Legislation of the Physicians Alliance Commission. ***Action:*** accepted.

Report H detailed the work of the Environmental and Occupational Health Committee during the past year. ***Action:*** accepted.

Report N summarized the new focus and newly defined charge for the Committee on Health Care Quality, Costs and Utilization. ***Action:*** accepted.

Report R highlighted the deliberations in which the Wisconsin Delegation to the American Medical Association was involved. Notable topics of discussion were AIDS and HIV infection, physicians' rights to dispense drugs, and continued physician difficulties with PROs. ***Action:*** accepted.

Report S noted the Wisconsin Nursing Association-State Medical Society Liaison Committee's policy recommendation of: "The Society supports the concept that nursing move toward two levels of licensure. These levels would be associate degree (technical) and baccalaureate degree (professional) . . ." ***Action:*** adopted.■

Presidential address

Kenneth M. Viste, Jr, MD

It is a privilege to be here this morning to share my experiences as your president this past year. I would like also to share with you my ideas on how we can continue to represent the best interests of medicine and our patients here in Wisconsin. It is hard to believe that it has been a year since I came before you with my views of the then upcoming year. I think that we have had many successes this year and I would like to review some of them for you.

As you know, my presidency was directed toward improving health care access and affordability for our patients. Much of my effort over the last year, as well as the efforts of many of you and our staff, has been directed toward PartnerCare. This was a program that operated successfully in several pilot counties but was not universal and was not meeting the needs of many of our financially precarious elderly. It was my feeling that we had to do something that was both credible and right, and that we must involve our patients in designing a program. These ideals were the genesis of a program that has become a model for the country. Through the efforts of you and your county medical societies, and the Coalition of Wisconsin Aging Groups, we have been able to put together a program assuring access to needed medical care for those of our elderly whose incomes are below 150% of the federally designated poverty level.

I have traveled the state promoting this program and working with the various physician groups and clinics to ensure its success. I have seen the problems with Medicare reimbursement levels and recognize the commitment many physicians and clinics have made to the program in spite of this. I have also spoken to the elderly in various senior centers and have participated in news conferences, TV shows, radio shows and newspaper interviews, to help the public understand and participate in the program. In the senior centers, I have seen first hand the benefits of the program. I have seen our financially distressed seniors getting easier access to affordable care. I have been gratified by the renewed trust in organized medicine that I have seen. I believe that most of us have always been willing to discount our fees to help those unable to afford them, but this program has truly brought this philosophy to a more meaningful level for our older patients.

As we all know too well, the Medicare system is flawed, and finding any long-term solutions requires that we physicians work together with our patients to design and administer a better and a more equitable system. PartnerCare is such a program and can serve as a model for creating new systems to address the problems of access and affordability. PartnerCare has

Kenneth M. Viste, Jr, MD

come a long way during this past year, but much still needs to be done if we are to continue to be effective.

I have recommended, and the Board of Directors has approved, the appointment of a PartnerCare Operations Committee to oversee the continuing implementation of this program and to ensure an ongoing, productive relationship with the Coalition of Wisconsin Aging Groups. I recommend that representatives from the Medical Society, the aging groups, and the clinic managers work together to make PartnerCare even more successful.

Obviously, much needs to be done to address the problems of the underinsured and uninsured in this state. I hope that the Medical Society continues to take constructive and progressive leadership positions in this area so that there is no citizen in this state without adequate access to affordable health care.

Secondly, I felt that the State Medical Society could do something about the challenges of rural health. I recommended, and the Board approved, the formation of a Task Force on Rural Health. I was privileged to serve as its chairman. We brought together physicians, as well as many well-informed non-physicians, from all corners of the state. Together, we polled our rural physicians and analyzed the status of rural health and the changes needed to ensure its vitality. Not surprisingly, we found that Medicare reimburses rural hospitals and rural physicians much less for similar procedures and illnesses as compared to their urban counterparts. This factor alone threatens the financial

viability of the rural health system and makes it difficult to recruit physicians for rural areas. Also, we found that the present educational system does not always cast rural medicine in the most favorable light. It is our feeling that quality medicine can, and is, practiced in our rural areas and that more effort is needed to influence our educators so that their students will consider practice in smaller areas worthwhile.

We also found that hospitals, physicians, and their communities were economically entwined, and that a healthy economic development picture must include a health system where there is synergy among physicians, their hospitals and their communities. The task force came up with many recommendations, and it will be the job of the Medical Society in the months and years ahead to put them into effect.

I was also concerned last year about regulatory accountability, specifically that we had a Medical Examining Board with a woefully long backlog of cases, and one that was not responding to many of the recommendations made by committees formed by the governor or SMS. The secretary of regulation and licensing has discussed some of these issues with the SMS Board of Directors, but certainly more needs to be done. As you know, we in organized medicine are often criticized for failing to do something about the "bad doctor" when, in fact, only the Medical Examining Board can alter or take away a physician's license. We must have an examining board that accurately disciplines physicians in a just and timely manner.

In looking at the Medical Society and the many changes that have occurred over the past two years, it was our feeling that the time had come for a long-term look at the purpose of the Medical Society and its various programs. In other words, we needed a strategic plan for our future. We polled the members of the Society and held a number of meetings to help chart our future course. I am happy to report that most members feel that the Medical Society is functioning well and fulfilling its purpose, although some adjustments in our priorities are in order. The Strategic Plan recommends that more emphasis be placed on physician representation to government, particularly at the federal level, and that more be done to communicate medicine's concerns and needs to the public.

A number of other major events have occurred this year. We had a successful leadership conference in October, during which we had opportunity to hear many good speakers and to work on the Strategic Plan. We have a superb AIDS Task Force, ably chaired by Dr Kim Hetsko. This task force is at the forefront of formulating policy at the state level, as well as educating our own members to deal with the many perplexing issues generated by this disease. The task force has been quick to point out our obligation to care for these patients, as well as the need to protect and educate the public and our health care workers about the disease. The work of this task force has gone a long way toward lessening the potential hysteria over AIDS and in providing constructive approaches to the disease.

This has also been a year of building better relationships with others who have a concern for the health of Wisconsin citizens. We have instituted a regular semi-annual meeting of our Executive Committee and that of the Wisconsin Hospital Association. Likewise, we have met several times with, and have established a better relationship and line of communication with, our governor.

We started the year with a great deal of division and conflict over strategies for management of the medical liability crisis. We had a great deal of healthy debate (and some not so healthy) and have come to a consensus for future activity, including the establishment of a blue ribbon committee to look at ways of setting up an entirely different system of conflict resolution.

During the course of the year, I have had the pleasure of representing you in all parts of the state. I have seen first hand the vitality and commitment of our physicians to their patients' welfare at a time when their own environment is becoming less and less certain. I have seen young physicians struggling to become established and to pay off their education debts, and I have seen older physicians who are retiring prematurely because of escalating medical liability costs. I have seen all physicians working in a system that is increasingly intrusive in their doctor-patient relationships and is increasingly second guessing their medical decisions.

I have also had the opportunity to meet and discuss issues with physicians in a variety of settings. I have driven nearly 20,000 miles, from Beloit, Monroe and Lancaster in the south to Baldwin and Superior in the north, from La Crosse in the west to Sturgeon Bay and Manitowoc in the east. I have sensed a growing concern about the future of medicine but I have also become convinced that we in Wisconsin can, and will, adapt to our changing environment in creative and constructive ways.

Looking toward the future, we can do some things to ensure our continued success, with both the public and our elected officials. We must keep a strong central staff to analyze issues and help us formulate policy. We need to reach out to our widely scattered members so that they may become better informed and may participate more fully in the creation and execution of our policies. This will require more effective and better communication. Our bimonthly newsletter, *Medigram,* is working well as a communications tool. A new editor and staff of the *Wisconsin Medical Journal* will doubtlessly mean changes in style and design, yet its editorial excellence will be maintained.

However, I believe that our leadership and executive staff need to be more visible and more active across the state. I believe the leadership needs to make regular visits to the major media centers of this state to establish open lines of communication with our state's journalists, helping them better understand medicine's views and concerns as they relate to the

health of Wisconsin's citizens. As I have found out first hand, Wisconsin is a very large state, particularly if you are driving from Monroe to Superior as I did the other day, and it becomes increasingly difficult for leadership physicians to visit the less populous areas of the state. I feel that the Medical Society should investigate the possibility of using an airplane to enhance our communication abilities. The craft could also be used for representation of our interest in Washington. Indiana has such a system, and it has greatly strengthened internal and external communication, and has been cost effective as well.

Considering the myriad issues confronting us, we need to be more active and more visible in major health issues—taking active roles in promoting better highway safety laws, such as our recent campaign for mandatory seat belts and better drunk driving laws—as well as in public health areas such as AIDS. It is in many of these areas that we as physicians are the most knowledgeable resources for society, and we must stand up for what we know is right and we must work for policies that enhance the health of our fellow citizens.

It has been my privilege to participate in the deliberations of many Medical Society committees. We have attracted truly outstanding leaders who travel many miles and spend countless hours in formulating our Society's policies. These committee chairmen and members are frequently not recognized for all they do to help make this an effective society. I am sure that you join me in thanking them for their continuing efforts. In the same fashion, it has been my pleasure to work with the Medical Auxiliary under the leadership of Barbara Newcomer. She has worked to truly make the activities of the Auxiliary relevant to today's Medical Society and the needs of its members. The Wisconsin Workshop on Health, addressing drug abuse and suicide for high school students this past fall, was particularly effective.

In looking back at the many activities that I have been involved in this past year, I must give thanks and appreciation to the dedicated and hard working staff of the State Medical Society. They have been a source of support and encouragement and have worked hard to keep me organized. My effectiveness in large part has been a product of their diligence, insightful analysis, and commitment to our goals. To a person, they have always been willing to help make this Society more effective. Our propensity for weekend and evening meetings has not deterred them in their efforts. It is difficult to know how to thank them properly but I shall try. I have purchased a membership in the Beaumont 500 in their honor to express my appreciation for their help and friendship this past year.

In closing, I want to thank you again for your support and encouragement this year. We have a great Society and a great commitment to the enhancement of the health of the citizens of this state. I shall continue to devote my energies to our efforts, particularly in ensuring the continued success of PartnerCare. I appreciate the privilege of having been your president.■

Report of the president elect

JD Kabler, MD

In the year just past, your president elect has learned much by listening to members and officers and by participating in the work of the Society. I have learned that our Society is strong—three-fourths of Wisconsin physicians are members—and that it is well represented, well managed and well regarded. Our Society enjoys, to a degree rare among comparable medical associations, the confidence, support and participation of its members. We can justifiably point with pride to our Medical Society's publications for its members, the energy and credibility of its communications with public officials and its prompt responsiveness to the many issues arising in an unstable health care environment.

Nevertheless, there are unresolved matters which some view with alarm: the refractory professional liability crisis, the destabilization of health care systems familiar to and trusted by most patients, damaging excesses in marketing and cost shifting, and the growth of politically driven regulations intended to allocate constrained health resources equitably. There is an abundance of other problems which challenges us: the high costs of medical education with the resultant severe debt burden borne by young physicians, a concurrent declining commitment to primary care, a shortage of professional nurses which will worsen for the next several years, and growing threats from as yet incurable infections and degenerative diseases.

We are by no means the first to be challenged. In this context, it is instructive to look to the past for guidance by quoting a former president elect:

> With the mounting cost of living, the cost of illnesses has also risen. This is evident in the cost of hospitalization and all items which contribute to the care of the sick. Insurance is an accepted method in our country for spreading the cost of catastrophic disaster to what-

ever that may be due. The difficulty, however, is in devising a method which will preserve the high type of individual medical care to which our citizens are accustomed and the freedom of the physician to supply it without being subject to interfering directives.

Medical education is one of the problems that concerns both the public and the profession. Among the profession, it concerns those who teach in the classroom as well as those who teach in the office. Medical students in the mass are moving toward specialization. This has been brought about for a number of reasons: greater income, more leisure hours and professional recognition.

Medical education is concerned not alone with the education of the doctor, but also with the training of all those who are going to practice techniques which are subsidiary to the practice of medicine. The shortage of professional nurses raises a question in this connection. This is a matter which concerns nurses, physicians and the public. The two professional groups are the ones to whom the public has a right to look for constructive action.

We must listen constantly and attentively to the opinion of the opposition, lest they may have expressed an idea which should be ours or to which we should agree. As public-spirited citizens, we are obligated to be not only informed . . . but active in politics to establish effective government. It is shirking duty to stigmatize these agencies with the word "political" and thus excuse our inactivity.

These quoted remarks by Dr William Stovall, distinguished physician, educator and medical statesman, are from his report to this House of Delegates in 1948.

Despite contemporary problems which appear so large because they are so close, is it possible to look to the future with confidence? I think it is and that we should. Some problems *are* solved. In 1948, the infant death rate was more than three times that of today, maternal mortality was twenty-six times that of today, and poliomyelitis was a major problem. Although we now have AIDS and Alzheimer's disease with which to contend, our profession is younger, more numerous, better educated, and armed with more powerful means to cure, to palliate and to comfort than ever before.

Roger L. von Heimburg, MD, (l) chairman of the SMS Board of Directors, swears in JD Kabler, MD, (r) as the new SMS president.

The draft of the Strategic Plan which you will ponder during these sessions of the House puts forward many proposals for the future. Of course, not all can or should be implemented immediately and some will oblige substantial thought and discussion. Implicit among the latter are two which I wish especially to stress.

1. What if our current efforts toward tort reform do not prevail or do not suffice? We need now to examine and consider a more fundamental remedy: a defined compensation plan for patients with serious unwanted outcomes which is not contingent upon a legal lottery or an artificial assignment of imputed negligence.

2. We should plan and fund improved communication with the people of Wisconsin now. Activities to enhance the reputation and credibility of our profession should include descriptions and explanations of physicians' many contributions to the health of the public, as part of an observance of the State Medical Society's 150th anniversary in 1992.

Whatever the outcome of our current and future deliberations, to judge from the past one can predict that our profession and our Society will not merely survive but will surmount the problems of our day and conscientiously continue to serve the people of Wisconsin. Serving with you in the year to come will be an honor and a challenge; I look forward to it with pleasure and optimism.

Thank you.■

Health care for the uninsured

Secretary's annual address

In my address to this House of Delegates last March, I noted an inscription in stone near the roof of the National Archives Building in Washington, DC: "The past is prologue to the future." Those seven simple words resonate throughout recent medical history. Looking back at the previous year, I am struck by the high level of activity carried out by the Society in 1987–88. What's even more striking is that the Society, its committees, commissions, and board members, as well as its staff, undertook many varied tasks, producing reports that will guide policymakers over the near- to mid-term.

Dr Viste has already outlined many of those undertakings, including:

1) Continued work in the area of tort reform

Our ongoing legislative and research efforts will be supplemented by the deliberations of the Blue Ribbon Task Force on Alternatives to the Tort System. This task force and SMS will actively explore new means to resolve the inequities of our state and nation's medical malpractice tort system, and to build a consensus for change.

2) Development and implementation of PartnerCare

The Society and Coalition of Wisconsin Aging Groups' statewide expansion of our voluntary Medicare assignment program for low-income elderly has won national recognition. This innovative approach reduces barriers to access for care for the near-poor elderly, and enhances communication between our organization and the statewide aging network.

3) Successful efforts by the AIDS and Rural Health task forces

These two SMS task forces worked long and hard to successfully formulate novel approaches to dealing with two of the most pressing issues facing medicine and society today.

4) Formation of a strategic plan

Through the efforts of the Executive Committee, the Society developed its Strategic Plan, which will be considered by this House of Delegates. If adopted, the Society can benefit from a flexible blueprint for action—a plan grounded in the history of past activity, yet adaptive enough to meet the needs of tomorrow.

These and a host of other priorities occupy our time as we move forward to meet the changing demands of our members and the public.

The principal topic of my address today is a pressing current issue: health care for the uninsured. More than a half million Wisconsin residents are presently without medical insurance, and thousands more are underinsured, unable to afford or obtain the health coverage they want or need. These people are forced to gamble their physical and financial well-being in a daily game of medical Russian Roulette played out within the confines of the country that provides the finest health care in the world.

The late Minnesota Sen Hubert Humphrey, in his final official address, told a special session of the US House of Representatives that "the moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life—the sick, the needy, and the handicapped."

Thomas L. Adams

With an estimated 553,000 people in Wisconsin lacking adequate health care protection, our state government, business and industry are not meeting the moral standards so eloquently advanced by Sen Humphrey. Government and business-bashing, however, will not substitute for constructive work toward a statewide solution in this critical area. Many employers must share the blame for perpetuating policies devoid of compassion for those experiencing true financial hardship.

With an estimated 553,000 people in Wisconsin lacking adequate health care protection, our state government, business and industry are not meeting the moral standards so eloquently advanced by Sen Humphrey. Government and business-bashing, however, will not substitute for constructive work toward a statewide solution in this critical area. Many employers must share the blame for perpetuating policies devoid of compassion for those experiencing true financial hardship.

The time has come for government and business to face the issue of uninsured health care. The days of cost-shifting are over. The advent of DRGs, the physician fee freeze, and the shift from traditional to managed care plans have rendered physicians and hospitals unable to continue paying for uncompensated care. It's time to stop robbing Peter to pay Paul.

Who are Wisconsin's uninsured? A 1986 survey conducted by the Wisconsin Division of Health esti-

mated that about 553,000 people in Wisconsin were medically uninsured. This equals 12% of the state's population. In 1981, some 414,000 people, or 9% of the general population, were estimated to be uninsured. Thus, the uninsured population in Wisconsin grew by some estimates as much as 31% in five years.

These surveys paint a picture of the uninsured as mostly young, low-income, and tied to the workforce. While most uninsured citizens are medically or financially unable to obtain health insurance, a subgroup of young people choose to go without health insurance, and some companies hire part-time help to avoid the responsibility of providing even minimal insurance coverage. These young people, who are immortal in their own eyes, and the companies that chose not to provide basic coverage, extract a financial toll from the rest of society by their irresponsible behavior. This statewide profile of the uninsured is nearly a carbon copy of the national picture.

The trend indicated by these recent surveys will likely worsen for several reasons:

1) The federal government will seek to keep a lid on, or further reduce, Medicare and Medicaid costs to decrease the national debt, thereby causing further cost-shifting to state governments and the private sector.

2) Wisconsin state government, for valid fiscal reasons, will balk at funding a full-scale program for the uninsured.

3) Employers will seek new ways to curtail existing health benefit plans as health care costs continue to rise, due to an aging population, expensive technological advances, skyrocketing malpractice premiums and the failure of government health care programs to pay their true share of the health care bill.

The State Medical Society of Wisconsin officially addressed the problem of the uninsured in 1973, when its House of Delegates voted to support proposed federal legislation, then known as the Medicredit Insurance Bill, which included a $250,000 catastrophic illness provision. This firm stance excited much controversy at the time.

It is exactly this type of tough decisionmaking, that is now needed to address this problem. The Society's involvement in aiding the uninsured in Wisconsin is also illustrated by our recent affiliation with the WeCare and ShareCare programs and our ongoing commitment to Wisconcare and PartnerCare. The Society's ad hoc committee on the uninsured, which met during 1986 and 1987, and was chaired by Dr Delore Williams, emphasized the multi-faceted nature of the problem. Any viable solutions must address three areas: need, cost, and funding.

Need

The need to make private health insurance available to a large pool of primarily young, low-income and working people is clear. Presently, uninsurable people can already obtain medical insurance through Wisconsin's health insurance risk-sharing plan, although the cost is nearly prohibitive for many.

A program to assist Wisconsin's uninsured must be comprehensive enough to include every subgroup not currently covered by health insurance, and versatile enough to meet the individual needs of the various groups. Full- and part-time workers, homemakers, students, the unemployed, disabled, and retired all have unique needs and varying abilities to pay.

Cost

The potentially high cost of providing health insurance to the uninsured population appears to be the major stumbling block in getting Wisconsin's long-planned state health insurance program, known as SHIP, launched and sailing. The Governor's Council on the Uninsured produced an extensive plan in January 1987, calling for the implementation of several pilot projects. All plans to initiate the SHIP pilot projects, however, were subsequently shelved, effectively lowering SHIP's sails and keeping it in port.

I'm reminded of the popular commercial where a repairman shrugs and says, "You can pay me now, or you can pay me later." It is well documented that deferring needed medical care only leads to more severe health problems and bigger bills down the road. Our present hodgepodge of uncompensated care programs are largely carried out on the backs of physicians and hospitals. Physicians and hospitals, however, cannot afford to continue footing the bill for an item which is rightly a responsibility shared by the public and private sectors.

Last week the state legislature considered a welfare reform bill which resurrected three of the original SHIP pilot programs. These pilots target three main areas: 1) difficulties small employers face with financing health benefits for their employees, 2) working people who cannot afford employer-provided health insurance, and 3) low-income people who are at medical risk and who are therefore, priced out of the private insurance market. This downscaled plan would be a welcome, but modest, step toward meeting the pressing needs of some of our state's most vulnerable citizens. The SHIP pilots, however, serve only as a holding action against the growing pressures on our present non-system of uncompensated care.

Funding

State general purpose revenue must be made available to supplement financing for a private health insurance program which will cover all uninsured persons in Wisconsin. Government must continue as a financial player in this arena. Cost-sharing by beneficiaries should be required based on the recipient's ability to pay.

All employers, large and small, must also join in the effort to make affordable, adequate health insurance available to their employees.

I propose that all Wisconsin employers provide basic health coverage, including catastrophic, to all workers and their families. Further, I submit that all

employees should be required to take part in their company's group enrollment plan, the only exception being for those individuals covered by a spouse or other family member's plan. Employers should pay at least 80% of the premium for a basic package and 100% for very low wage workers.

Employees should retain the right to choose between competing plans in the private market, paying the difference for higher cost plans if they so choose. Such a program should be administered by private carriers, for the last thing anybody needs is another government-run program. We may pay a nickel more for a hamburger or a six-pack, but that's a small price to pay to combat a burgeoning problem. State government can help facilitate this effort by providing an income or excise tax credit in the program's early going.

We must also require those companies that self-insure to pay their fair share. Under a federal law known as ERISA, the Employee Retirement and Income Security Act, companies that self-insure are shielded from contributing to state insurance risk-sharing pools. In Wisconsin, a majority of employers have jumped on this self-insuring bandwagon, leaving a minority of mostly small businesses to pay the bill. This is patently unfair. I believe that the AMA should continue to seek amendments to ERISA that would end this unfair loophole for big business. I would also propose that Wisconsin follow Hawaii's lead and seek an exemption from the ERISA preemption barrier to self-insured participation in state insurance pools.

Critics will claim that requiring employers to provide minimal insurance coverage to their employees places Wisconsin employers at a competitive disadvantage. This argument, however, does not hold water, as a healthy citizenry is the foundation for any state's economic climate. The heart of the matter is that the cost of health care for the uninsured is now and will be borne by someone—and a fairer distribution of that cost will be achieved by adding employers to the list of physicians and hospitals already picking up the tab for everyone else.

The newly created Governor's Council on Pilot Projects ought to seriously explore the ideas I have outlined as it begins its deliberations. For our part, I recommend that the State Medical Society convene a Task Force on Health Care for the Uninsured, which will address issues beyond the scope of the state's pilot projects. Clearly, we can not afford to continue postponing the hard choices we must make to better serve the uninsured in Wisconsin.

We should strike now with an early call to action on the part of the public and private sectors in Wisconsin. In the words of President John F. Kennedy, "If not us, who? If not now, when?"

Thank you for your time and attention. I look forward to working with you on this and other important issues in the year to come.■

THE OATH OF HIPPOCRATES

I SWEAR BY APOLLO, THE PHYSICIAN, AND AESCULAPIUS AND HEALTH AND ALL-HEAL AND ALL THE GODS AND GODDESSES THAT, ACCORDING TO MY ABILITY AND JUDGMENT, I WILL KEEP THIS OATH AND STIPULATION:

TO RECKON him who taught me this art equally dear to me as my parents, to share my substance with him and relieve his necessities if required; to regard his offspring as on the same footing with my own brothers, and to teach them this art if they should wish to learn it, without fee or stipulation, and that by precept, lecture and every other mode of instruction, I will impart a knowledge of the art to my own sons and to those of my teachers, and to disciples bound by a stipulation and oath, according to the law of medicine, but to none others.

I WILL FOLLOW that method of treatment which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel; furthermore, I will not give to a woman an instrument to produce abortion.

WITH PURITY AND WITH HOLINESS I will pass my life and practice my art. I will not cut a person who is suffering with a stone, but will leave this to be done by practitioners of this work. Into whatever houses I enter I will go into them for the benefit of the sick and will abstain from every voluntary art of mischief and corruption; and further from the seduction of females or males, bond or free.

WHATEVER, in connection with my professional practice, or not in connection with it, I may see or hear in the lives of men which ought not to be spoken abroad, I will not divulge, as reckoning that all such should be kept secret.

WHILE I CONTINUE to keep this oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men at all times; but should I trespass and violate this oath, may the reverse be my lot.

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T—Richard Friedman, MD
600 Highland Ave
Madison 53792

Wisconsin Neurosurgical Society

P—Marc A. Letellier, MD
631 Hazel St
Oshkosh 54901

PE—Patrick Walsh, MD
18170 Midland Place
Brookfield 53005

VP—Donald B. Kelman, MD
1000 N Oak Ave
Marshfield 54449

ST—Lincoln Ramirez, MD
Dept. of Neurological Surgery
H4/334 UW CSC
600 Highland Ave
Madison 53792

Wisconsin Society of Obstetrics and Gynecology

P—Thomas A. Hofbauer, MD
W180 N7950 Town Hall Road
Menomonee Falls 53051

PE—William E. Martens, MD
10425 W North Ave, #226
Wauwatosa 53226

ST—Paul G. Harkins, MD
1000 N Oak Ave
Marshfield 54449

Wisconsin Academy of Ophthalmology

P—Dennis Kontra, MD
5802 Washington Ave
Racine 53406

PE—Peter J. Mc Canna, MD
1025 Regent St
Madison 53715

ST—Jack L. Hughes, MD
Suite 607
2500 N Mayfair Road
Milwaukee 53226

ES—Robert H. Herzog
850 Elm Grove Road
Elm Grove 53122

Wisconsin Orthopaedic Society

P—Michael C. Reineck, MD
1201 Oak St
West Bend 53095

ST—William P. McDevitt, MD
Suite 310
2323 N Mayfair Road
Milwaukee 53226

Wisconsin Society of Otolaryngology—Head and Neck Surgery

P—Thomas M. Kidder, MD
2901 W Kinnickinnic River Parkway, Suite 201
Milwaukee 53215

PE—S. Thomas Donovan, MD
1313 Fish Hatchery Road
Madison 53715

ST—Donald S. Blatnik, MD
2400 S 90th St
West Allis 53227

Wisconsin Society of Pathologists

P—David J. Rothwell, MD
Columbia Hospital
2025 E Newport Ave
Milwaukee 53211

VP—Richard A. Komorowski, MD
8700 W Wisconsin Ave
Milwaukee 53226

S—Gerald A. Hanson, MD
8700 W Wisconsin Ave
Milwaukee 53226

T—Jay F. Schamberg, MD
S47 W22060 Lawnsdale
Waukesha 53186

Wisconsin Chapter: American Academy of Pediatrics

P—Gerald E. Porter, MD
1000 N Oak Ave
Marshfield 54449

PE—Ordean L. Torstensen, MD
1313 Fish Hatchery Road
Madison 53715

ST—Joanne Selkurt, MD
1897 Lincoln St
Whitehall 54773

Wisconsin Society of Physical Medicine and Rehabilitation

P—Ram P. Bhala, MD
2900 W Oklahoma Ave, 417
Milwaukee 43215

PE—Donna D. Davidoff, MD
2323 North Lake Drive
Milwaukee 53211

ST—Sridhar V. Vasudevan, MD
5000 W Chambers Ave
Milwaukee 53210

Wisconsin Society of Plastic Surgeons

P—Terrence J. Wilkins, MD
2015 E Newport Ave
Milwaukee 53211

VP—Reudi P. Gingrass, MD
9800 W Bluemound Road
Milwaukee 53226

ST—Paul W. Loewenstein, MD
Suite 950
2300 N Mayfair Road
Wauwatosa 53226

Wisconsin Society for Preventive Medicine

P—Henry A. Anderson, III, MD
Division of Health
PO Box 309
Madison 53701

ST—Constantine Panagis, MD
9609 W Hadley
Milwaukee 53222

Wisconsin Psychiatric Association

P—Pauline M. Jackson, MD
1836 South Ave
La Crosse 54601

PE—Donald P. Hay, MD
Suite 302
2015 E Newport Ave
Milwaukee 53211

S—Steven V. Hansen, MD
1220 Dewey Ave
Milwaukee 53213

T—Kathryn C. Bemmann, MD
412 N West Ave
Waukesha 53186

Wisconsin Society of Radiation Oncologists

P—Alan B. Fidler, MD
St Luke's Hospital
2900 W Oklahoma Ave
Milwaukee 53215

PE—Homer H. Russ, MD
611 St Joseph Ave
Marshfield 54449

S—Sally M. Schlise, MD
St Vincent Hospital
835 S Van Buren
Green Bay 54305

T—Richard A. Steeves, MD
K4/B100 UW CSC
600 Highland Avenue
Madison 53792

Wisconsin Radiological Society

P—Robert Durnin, MD
110 N Yellowstone Drive
Madison 53705

PE—Eric B. Wilson, MD
4397 Country Club Road
Oshkosh 54901

VP—James E. Youker, MD
8700 W Wisconsin Ave
Milwaukee 53226

ST—Paul Bolich, MD
1586 Arapahoe Court
Green Bay 54303

Wisconsin Surgical Society

P—Stuart D. Wilson, MD
8700 W Wisconsin Ave
Milwaukee 53226

PE—George M. Kroncke, MD
6006 Galley Court
Madison 53705

ST—J. David Lewis, MD
279 S 17th Ave
West Bend 53095

Wisconsin Chapter: American College of Surgeons

P—Sanford Mackman, MD
345 W Washington Ave
PO Box 222
Madison 53701-0222

PE—Roger L. von Heimburg, MD
900 S Webster Ave
Green Bay 54301

VP—Paul S. Fox, MD
1111 Delafield St
Waukesha 53188

ST—Ronald D. Wenger, MD
1912 Atwood Ave
Madison 53704

Wisconsin Urological Society

P—Reginald Bruskewitz, MD
600 Highland Ave
Madison 53792

PE—Richard Bourne, MD
Suite 545
2600 Mayfair Road
Milwaukee 53226

ST—Clyde C. Lawnicki, MD
1836 South Ave
La Crosse 54601■

SMS Placement Service aids physicians and communities

ONE OF THE MANY FUNCTIONS of the State Medical Society of Wisconsin is to assist physicians who are seeking a location to practice in Wisconsin and to assist communities seeking the services of physicians.

The Society's Placement Service maintains a continuous listing of names and biographical data on physicians who wish to locate in Wisconsin. Files are maintained on communities desiring physicians. Information is exchanged with interested physicians and communities, with the American Medical Association, and with the two Wisconsin medical schools. There is no charge to either physician or community for this service.

A list of openings is sent to physicians who contact Placement Service indicating a desire to locate in Wisconsin or to relocate within the state. A list of physicians is sent to communities requesting assistance in obtaining a physician. The physicians and communities may then contact one another. Physicians seeking associates also may request a listing of available physicians.

Experience of Placement Service shows that physicians seek locations on a long-range basis—some are available at once, while others are in residency for two or three years. One word of advice: Advise the Society's Placement Service of your needs as soon as possible. Overnight results occur but more time usually means better results.

It should be noted that Placement Service is not a recruiting effort. Its function is supported by membership in the State Medical Society of Wisconsin. The Society does, however, cooperate with the state-supported Office of Rural Health in its New Physicians for Wisconsin Program which provides placement services to communities and physicians on a fee basis determined by budgetary funds available.

Physicians and communities also may utilize the "Medical Yellow Pages" section of the *Wisconsin Medical Journal.* This classified advertising section is available to members of the State Medical Society, other physicians, communities, clinics, hospitals, recruitment firms, and others at reasonable rates.

Physicians using the Placement Service have described it as one of the most effective in the United States. *Journal* advertising, too, has proved highly successful.

Inquiries should be addressed to Placement Service, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701; tel 608/257-6781; and/or *Wisconsin Medical Journal,* Box 1109, Madison, Wis 53701.■

DISTRICT 1
Lois Riley
(414/271-4328)

County medical societies

Milwaukee
Waukesha
Ozaukee
Washington
Sheboygan
Kenosha
Racine
Walworth

DISTRICT 2
Deborah Bowen Wilke
(608/257-6781)

County medical societies

Columbia-Marquette
Adams
Green Lake-Waushara
Lafayette
Richland
Jefferson
Green
Iowa
Grant
Rock
Dane
Dodge
Juneau
Sauk

DISTRICT 3
Paul Markowski
(608/257-6781)

County medical societies

Oneida-Vilas
Lincoln
Marinette-Florence
Forest
Langlade
Shawano
Outagamie
Brown
Door-Kewaunee
Calumet
Oconto
Marathon
Wood
Portage
Waupaca
Winnebago
Fond du Lac
Manitowoc

DISTRICT 4
Tom Stoebig
(608/257-6781)

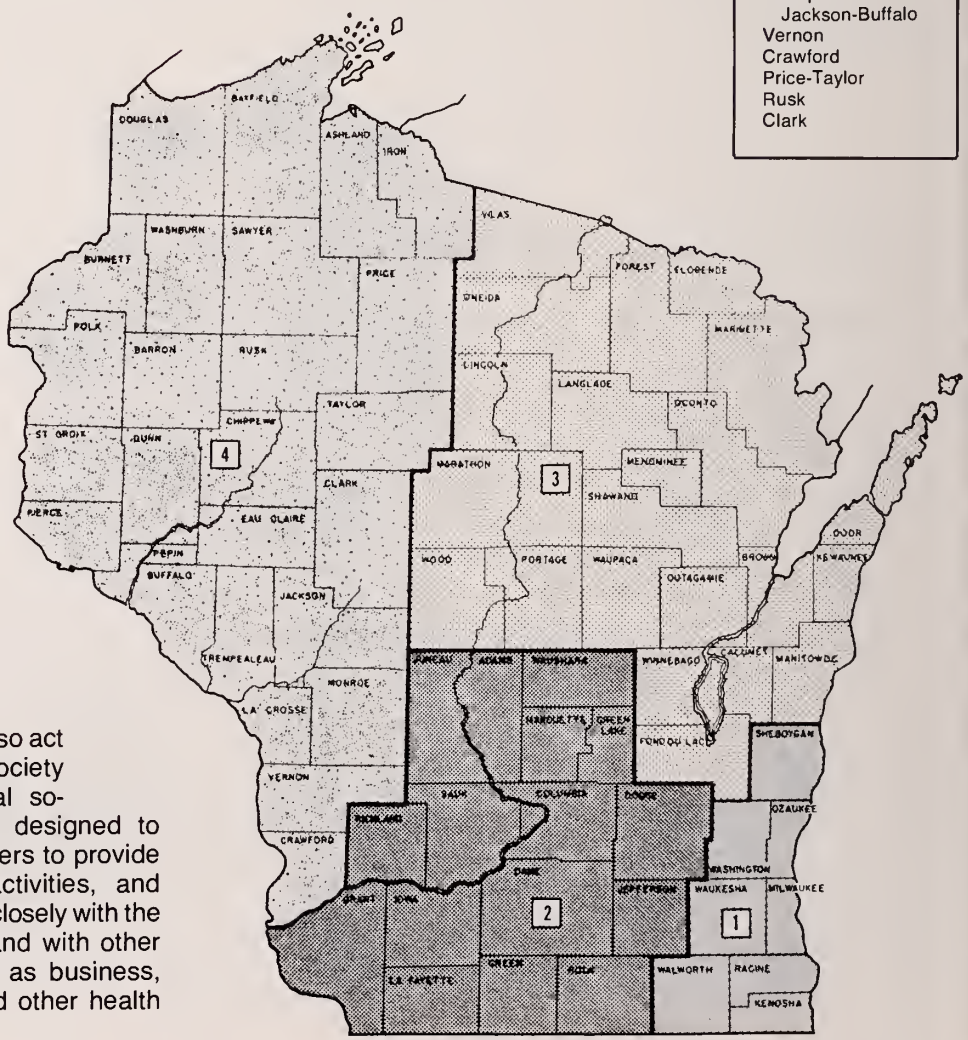
County medical societies

Ashland-Bayfield-Iron
Douglas
Barron-Washburn-Burnett
Sawyer
Polk
Pierce-St Croix
Chippewa
La Crosse
Monroe
Eau Claire-Dunn-Pepin
Trempealeau-Jackson-Buffalo
Vernon
Crawford
Price-Taylor
Rusk
Clark

1988 Public Affairs Districts and Medical Society Relations Staff

The primary function of the Division of Public Affairs is to effectively implement the Society's legislative program while promoting member awareness of and involvement in the political process. The activities of the Division are carried out by the lobbyists, support staff, and a network of Medical Society Relations staff.

In addition to their legislative and political responsibilities, Medical Society Relations staff also act as a liaison between the State Society and component county medical societies. The liaison function is designed to promote opportunities for members to provide input to Society objectives, activities, and priorities. Division staff also work closely with the clinic managers and hospitals and with other organizations and groups such as business, senior citizen groups, labor, and other health care organizations.



Wisconsin Physicians Political Action Committee and Physicians for Better Government

The Wisconsin Physicians Political Action Committee (WISPAC) is a voluntary, nonprofit organization. Membership consists of physicians and their spouses. Restricted from making political contributions, the State Medical Society created WISPAC to provide the medical profession with an opportunity to assume a more active and effective role in the political process. WISPAC is governed by a board of directors, traditionally concentrates on state legislative races and cooperates with the American Medical Association Political Action Committee (AMPAC) at the national level.

Physicians for Better Government is a political conduit established in 1987 by the WISPAC Board of Directors. Political conduits have the identical goals of political action committees with one distinctive feature. Members retain the right to decide who receives their contributions. Physicians for Better Government contributions are deposited in a special account in the member's name. No contribution is made to a candidate without the member's authorization. Political conduits complement political action committees. WISPAC and Physicians for Better Government double the political effectiveness of organized medicine in Wisconsin.

WISPAC and Physicians for Better Government are administered by the State Medical Society Division of Public Affairs. Please contact the division at SMS headquarters for additional information at 608-257-6781 or 1-800-362-9080.

Membership. Contributions may be sent to:

WISPAC/Physicians for
Better Government
PO Box 2595
Madison, WI 53701

Suggested membership categories include:

$200 Sustaining	($100 Physicians for Better Government, $50 WISPAC, $50 AMPAC, unless otherwise specified)
$100 Regular	($60 Physicians for Better Government, $20 WISPAC, $20 AMPAC, unless otherwise specified)

$40 WISPAC and AMPAC only

$20 WISPAC only■

Physicians Insurance Company of Wisconsin

State of the corporation

The Physicians Insurance Company of Wisconsin entered 1987 struggling to gain acceptance after a monumental effort that led to establishment of the company. A key concern throughout 1987 was to assure Wisconsin physicians that the company offered an appropriate and effective solution to many of the past problems of insurance coverage, as well as a sound investment.

At that time, PIC-Wisconsin had projected a 60% retention of policyholders previously written through The Professionals. Many physicians' initial reaction against the company and its claims-made product forbode a very difficult journey for acceptance.

Early in 1987, PIC-Wisconsin had established a base of 1,600 insureds, representing slightly more than 70% retention of former insureds of The Professionals. PIC-Wisconsin had not, however, retained a number of key groups that would have truly solidified its base. Fully 15% of the business at that time was from medical residents, and another 10% to 12% from first-year and second-year practitioners. PIC-Wisconsin actively pursued its goal of regaining as many of those established physicians and physician groups who, for whatever reason, chose not to renew in late 1986.

Through October of 1987, PIC-Wisconsin succeeded in doing exactly that. Its in-force policy count is now greater than 2,700 physicians. Several large clinics (which were previously insured with The Professionals and chose another carrier in 1986) selected PIC-Wisconsin for coverage in 1987, adding nearly 250 additional insureds to PIC's policyholder base.

Financially, PIC-Wisconsin has exceeded expectations. Original estimates for the first full year indicated a profit of approximately $90,000. By the end of the third quarter of 1987, pre-tax income was over $250,000, and the fourth quarter was expected

PIC-Wisconsin
Board of Directors
Richard W. Edwards, MD, Chairman
Thomas L. Adams
Timothy T. Flaherty, MD
Jerome W. Fons, MD
John J. Gaughan, MD
Joseph K. Gilmore
JD Kabler, MD
William J. Listwan, MD
John P. Mullooly, MD
Daniel P. Schmidt
William L. Treacy, MD
Kenneth M. Viste, Jr, MD

to continue that trend. PIC-Wisconsin's rates and reserves continue to be conservative and appropriate for the market, yet highly competitive.

PIC-Wisconsin is gaining further acceptance from physicians, and the support from the State Medical Society of Wisconsin has been essential in its development. While many physicians may have at first been vocally opposed to a claims-made policy and a physician-owned company in general, a shift in attitude seems to have occurred. PIC-Wisconsin now has acquired a market share of approximately 40%.

Much of its progress is due to its ability to deliver what it stated it would provide: superior coverage appropriately priced, with direct physician involvement.

This issue of involvement is especially important, and on more than one occasion, physicians have expressed appreciation for claims and underwriting procedures that address the physician's greatest fears about medical professional liability carriers. At the same time, PIC-Wisconsin has achieved a balance because the board of directors has made sound decisions that will ensure the financial integrity of the company in the years to come.

Projections: 1988 and beyond

PIC-Wisconsin is in a strong position to increase its policyholder base in 1988. It has developed a strategic plan that includes increased marketing efforts directed toward larger medical groups and toward the development of new products that may include a clinic policy.

At the same time, it intends to explore the desirability of offering professional liability coverage to other markets, including dentists and nurses.

In addition to specialized communication with physicians, with emphasis upon medical professional liability trends, PIC-Wisconsin will be developing educational materials to help policyholders better understand the elements that lead to malpractice lawsuits. It will also continue its efforts to explain the company's progress and fiscal stability to physicians and policyholders throughout the state.

PIC-Wisconsin will intensify its efforts to motivate the existing sales force and will establish additional agents to serve PIC-Wisconsin. Contact and communication with the State Medical Society, regional and specialty medical groups, and regulatory agencies also will be an important function.

In 1988, the company will be more visible not only as the largest writer of medical professional liability insurance in the state, but in other areas as well. This will call for increased emphasis on educational efforts and other services provided to physicians, including risk management and loss awareness information. PIC-Wisconsin will actively participate with medical and regulatory agencies in efforts in which the company may be directly impacted by decisions taken by those entities.

PIC-Wisconsin has established a strong foundation and reputation with an emphasis on profitability, and it will continue to maintain this position in the years ahead.■

Awards presented at the SMS annual meeting

Physician-Citizen of the Year Award

The Physician-Citizen of the Year Award has been presented since 1982 to a Wisconsin physician for outstanding contributions to his or her community and patients. This year—for the first time—the award was given during the SMS annual meeting. George E. Gutmann, MD, of Janesville, was the 1988 recipient. Dr Viste's remarks on presenting the award were as follows:

"Tonight we honor as physician-citizen of the year Dr George E. Gutmann, physician, teacher, musician, artist, community leader, humanitarian and good friend to many in his Janesville community.

"Dr Gutmann exemplifies the highest ideals of the medical profession, not only for the excellence he has demonstrated in the field of medicine, but also by his caring and concern for the quality of life for his patients and for his community.

"Dr Gutmann served Janesville and Rock County as a physician for 39 years before formally retiring from his practice last year. His relationship with Mercy Hospital left a legacy of excellent patient care, administrative leadership and top-notch medical training that continues today.

"During his years with the hospital he served as chief of staff, president of the medical staff, chairman of the Department of Medicine and also as lecturer for the School of Nursing. He was also instrumental in establishing Mercy's intensive care unit, one of the first in southern Wisconsin, and he helped write the policies for the ICU and trained the staff. The unit's excellent reputation and high standards reflect his care for detail and his high expectations.

"Dr Gutmann's deep sense of caring was shown by his leadership in starting the Mercy Hospital Doctor-Clergy Committee. The purpose of this unique group is to forge a bond of understanding and good will between the clergy and hospital medical staff to the advantage of both groups and the hospital's patients. The group developed into a Doctor-Clergy Breakfast and later into a popular Doctor-Clergy Luncheon. Discussion topics have included medical ethics, abortion, holistic medicine, stress and the high cost of medicine. Recently more than 150 people attended its annual meeting.

Dr Gutmann has been involved with the Doctor-Clergy Committee for more than ten years.

"Dr Gutmann was also a founder of Rock Hospice Care, which was a spin-off from the Doctor-Clergy Committee. He served on the original board of directors, worked to secure community, financial and volunteer support, helped train the staff, and explored new ways of family support and respite care. Rock Hospice Care is a voluntary organization and receives no third party support. It still operates under its original philosophy of 'friends caring for friends' and continues to be a vital resource for patients and their families because of Dr Gutmann, who planted the idea, provided the direction, and sparked the enthusiasm in the community.

"Dr Gutmann's concern for community also motivated him to establish the first Visiting Nurse Association in Janesville 25 years ago. That agency has grown from a single patient the first year to a census last year of more than 1500. Dr Gutmann also helped organize the state's first Society of Internal Medicine, and he served as the president of the group.

"Dr Gutmann's artistic talents are well known and put to good use in the community. He is a highly regarded musician and has been active for many years in the Janesville Concert Association and the Beloit-Janesville Symphony. He is also a talented artist and has frequently donated his paintings to various charities for fund raising events. He is not content, however, just to practice his craft, but is also enthusiastic in sharing his knowledge with budding artists and musicians.

"On a personal basis, Dr Gutmann is respected and loved by those who know him. According to his friends, his warm smile and one-of-a-kind laughter are his trademarks and have endeared him to many. He uses his wonderful sense of humor to break down the barriers of isolation and begin friendly communication.

"Tonight the Society is pleased to recognize Dr George Gutmann for his many achievements as teacher, community leader and physician exemplifying the highest ideals of the medical profession. Through his talents, caring, and tremendous energy he has touched those around him and has improved the quality of life for his patients, for Mercy Hospital, and for the Janesville community.■

Civic Leadership Award

Timothy L. Flaherty, MD, of Neenah, was the recipient of this year's Civic Leadership Award. This award was established in 1972 to recognize an SMS member for outstanding contributions to the Society and to the community. Dr Viste's remarks on presenting the award to Dr Flaherty were as follows:

"For the past 20 years, Dr Timothy Flaherty has put into practice the ideal expressed by President Dwight D. Eisenhower that 'politics should be the part-time occupation of all citizens.' And he has practiced this occupation with great zest, intelligence and good humor. The result has been a stronger voice for organized medicine at both the national and state levels and better health care for the citizens of Wisconsin.

"Dr Flaherty received his MD degree from Marquette University in 1959. He served an internship at St Mary's Hospital in Milwaukee and completed a radiology residency at University Hospitals in Madison. He is currently chairman of the Department of Radiology at Theda Clark Regional Medical Center in Neenah and clinical professor of radiology at the University of Wisconsin-Madison and the Medical College of Wisconsin in Milwaukee.

"Beyond these professional accomplishments, Dr Flaherty has been an active leader in the State Medical Society. He was a member of the Board of Directors, serving as its vice chairman from 1978 to 1983. He served as president of the Society in 1984-1985, and he has also been an active member on a variety of SMS commissions and committees, including the Physicians Alliance Commission, the SMS Task Force on Physician Review and Discipline, the Task Force on Medical Liability, the Commission on Public Information, Young Physicians, as well as the WISPAC Board, and many others.

"He has referred to his year as president of SMS as one of turmoil. It was a year when a host of thorny issues began to intrude into the practice of medicine. As president, Dr Flaherty called for increasing physician involvement in government as government became more involved in medicine.

"In seeking solutions for the issues facing physicians, the House of Delegates created the Task Force on Medical Care at the 1984 annual meeting. This committee, chaired by President Flaherty and composed of 32 members plus an additional 96 work group members, was directed to examine major socioeconomic trends and issues affecting medicine and present its findings at the 1985 annual meeting. With Tim Flaherty at the helm, the committee responded dramatically. It presented a massive report containing 120 recommendations for meeting these challenges head on. The recommendations ranged from the basic—such as capitation payments for services—to the more complex—including a restructuring of the Society itself.

"Through his many years of association with the Society—as its president and through his many other leadership positions—Dr Flaherty has been a highly articulate exponent of medicine's views on a variety of legislative issues, and his experience has enabled him to enunciate opinions and practical solutions from a national as well as a state perspective. His contacts throughout the country in a variety of settings are legion; his opinions are well regarded; and his Irish humor is appreciated.

"I also want to mention tonight that Tim recently sought and was appointed last fall to the AMPAC board. AMPAC is organized medicine's strongest voice in the national political arena, and Wisconsin medicine is fortunate to have Tim Flaherty's representation on this prestigious board.

"Another well-deserved honor recently won by Tim Flaherty concerns his military service. Since

1963, he has been a member of the Wisconsin Air National Guard, his most recent post being assistant to the command surgeon for the Strategic Air Command located in Nebraska. Just this month, Gov Tommy Thompson promoted Brigadier General Flaherty to the rank of major general in a special ceremony at the state capitol. This promotion, which was approved by the US Senate in February, coincides with his three-year appointment as Air National Guard Assistant to the US Air Force Surgeon General in Washington. Please accept our congratulations and best wishes on your promotion, Dr Flaherty.

"I couldn't end this tribute to Tim Flaherty without mentioning his wife, Joan, who has contributed so much to Tim's success. Joan has always been at her husband's side as his biggest fan and supporter. She has lovingly helped raise their four children and countless times been the gracious hostess. She has also carved out her own niche through many contributions to the SMS auxiliary and especially the Winnebago County Medical Society Auxiliary. In presenting this award tonight to Tim Flaherty, I want Joan to know that we are also honoring her.

"Dr Flaherty, for your many years of dedicated leadership on behalf of medicine and for the citizens of Wisconsin, I am pleased to award you the State Medical Society of Wisconsin's Civic Leadership Award."■

Presidential Citation

Since 1959, the president of the State Medical Society, with the approval of the Board of Directors, has had the privilege of presenting a presidential citation to a physician or non-physician who has made a truly outstanding contribution to medicine or the public health.

This year Dr Viste awarded two Presidential Citations. The first was presented to the Coalition of Wisconsin Aging Groups for its role in the implementation of PartnerCare across the state. The second citation was given to George E. Collentine, MD, of Milwaukee for his leadership in a multitude of socioeconomic issues both on a national level and in Wisconsin through his service on the AMA Council on Medical Service and on the Wisconsin Delegation to the AMA.

The text of Dr Viste's speech to the House of Delegates in presenting the award to Shirley Doane, executive director of the Coalition of Wisconsin Aging Groups, follows:

"The coalition is being honored by the Society today for its active leadership and energetic participation in PartnerCare. As most of you know, PartnerCare—which has received national recognition—is an innovative, state-wide effort by the Society, the Coalition of Wisconsin Aging Groups, and county aging groups to assure access to health care for low-income senior citizens. Physicians who participate in PartnerCare agree to accept the Medicare-approved amount when treating qualifying senior citizens.

"The implementation of PartnerCare, which began a year ago, has been a priority for me this year as president, and I am pleased to tell you this morning that our efforts on behalf of the elderly low-income citizens of Wisconsin have paid off. More than 5,000 physicians across the state are participating in the program, and initial physician sign-up is now complete. The program now operates in more than two thirds of all Wisconsin counties, and many senior citizens are already enrolled across the state.

"Much of the program's success must be credited to the coalition, especially to Tom Frazier, who is the executive director; Betty Morey, the program coordinator of the coalition; and to Shirley Doane, the president. Without their leadership from the program's inception, PartnerCare could not have succeeded. I would also like to commend the VISTA representatives associated with the coalition. They helped greatly by publicizing the program through the aging network and by training the volunteers and county aging staffs certifying enrollees' incomes. The coalition has continued its support for PartnerCare through thick and thin, and we greatly appreciate its backing.

"The Coalition of Wisconsin Aging Groups is a statewide federation of some 560 organizations that represent and serve Wisconsin's older citizens. It is independent and nonpartisan with a diverse membership, and for more than ten years it has been the united voice of older citizens, speaking on issues of importance to its constituency and to all Wisconsin residents. Its specific goals during its ten-year effort have been to control health care costs, reduce dependency among the elderly, promote productive roles for older persons, and support tax relief for citizens of all ages.

"We at SMS have developed a satisfying working partnership—and also a friendship—with Tom and the other coalition staff, and we look forward to moving ahead to the successful completion of PartnerCare and perhaps on to other areas of mutual interest.

"On behalf of the Society, I am pleased to present this Presidential Citation to the Coalition of Wisconsin Aging groups. The award is being accepted by the president, Shirley Doane."

Dr Viste presented a second Presidential Citation during the President's Dinner. In making the presentation to George E. Collentine, MD, of Milwaukee, he said:

"I am especially pleased this evening to present a Presidential Citation to George E. Collentine, MD, of Milwaukee. For more than 25 years George Collentine has been a leader on a multitude of socioeconomic issues affecting medical practice in Wisconsin and the nation as a whole.

"George recently retired from the AMA Council on Medical Service after serving nine years, the maximum allowed under AMA rules. The Council on Medical Service is one of the premier organizations within the AMA structure, and members are elected by the House of Delegates. It is charged with evaluating the social and economic aspects of medical care—on behalf of the public and the profession—and recommending means to develop services in the

changing socioeconomic environment. It helps set the official AMA position on the major issues of concern to medical practitioners.

"George served with vigor and distinction on the council. He helped write reports on a variety of complex issues such as professional peer review and cost effectiveness. He also represented the council by speaking to numerous health-care-related groups throughout the nation from Indiana to Idaho. His colleagues at the AMA will miss his intelligence, warmth and good humor.

"George Collentine has dedicated his professional life to overseeing the delivery of quality health care to patients through his medical career and through his leadership in the State Medical Society and the Milwaukee County Medical Society.

"Dr Collentine graduated from the old Marquette Medical School in 1943 and spent nearly all of his medical career at St Mary's Hospital in Milwaukee. For more than 25 years he was the director of St Mary's Burn Center, which was founded in 1959. It was the fourth burn care center established in the US and the first ever in a private facility. Dr Collentine and his staff pioneered the use of massive doses of antibiotics and the team approach in treating burn patients. He was also a founding member of the American Burn Association.

"Last year Dr Collentine formally stepped down from his position at St Mary's and retired from his practice to assume the position of medical director at Blue Cross and Blue Shield United. In his new position George's responsibilities include organizing and overseeing a review system aimed at assuring quality medical care under the various Blue Cross delivery systems. These include both prepaid and traditional fee for service systems. Throughout the years, George has unabashedly expressed his belief that quality health care can be delivered by physicians no matter what the funding mechanism—prepaid or fee for service. As you can imagine, this belief once made him rather controversial among his medical colleagues.

"George Collentine has also been a leader in quality of care and other medical issues at the state and county levels through his involvement with the State Medical Society and the Milwaukee County Medical Society. He was a member of the SMS Board of Directors for five years, and he has also served on the Cancer Committee, the Public Relations Committee, the Commission on Scientific Medicine and others. From 1960 to 1978, he was a delegate or alternate for Wisconsin to the AMA. He was also president and chairman of the Milwaukee County Medical Society and has been active in various scientific medicine programs—as one colleague says, 'George has attended a million medical meetings.'

"Tonight, I would also like to express my thanks and good wishes to George's wife, Pat, for her support of Dr Collentine and of the Society. We all know that without her, he couldn't have done it.

"George, it is with great affection and good will that I present you with the Presidential Citation of the State Medical Society for your outstanding contributions to medicine and the public health in Wisconsin."■

Directors Award

The State Medical Society bestowed the Directors Award—its highest honor—on Darold A. Treffert, MD, during the April annual meeting in Milwaukee.

In presenting the award to Dr Treffert, Kenneth M. Viste, Jr, MD, SMS outgoing president said, "The Directors Award is granted only on occasion to those who have served with outstanding distinction the science of medicine, physicians and the public. In the 59 years since it was established, 49 awards have been made. Of those who have been its recipients, it may be said that they have personified the highest ideals in the devotion to the public good."

The text of the award presentation to Dr Treffert reads as follows:

"Darold A. Treffert, MD, has served the Medical Society in many capacities. He has been its president—one of the youngest in its history—and chairman of the board, and he has served and continues to serve with energy and distinction on a variety of committees and commissions. His achievements as a physician, as a public spokesman for what he has called the 'belegaled profession,' and as a person have inspired all of us.

"A native of Fond du Lac, Dr Treffert graduated from the University of Wisconsin Medical School in 1958 and served an internship at Sacred Heart General Hospital in Eugene, Oregon. He completed his residency in psychiatry at University Hospitals in Madison. In 1964, at the age of 31, Dr Treffert was named to head the Winnebago Mental Health Institute. He held that position until 1979 when he became executive director of the Fond du Lac County Health Care Center.

"Dr Treffert was a founding member of the Controlled Substances Board and served as its chairman from 1977 to 1982. One of his special achievements while chairman was his leadership in restricting prescriptions and sales of amphetamines in Wisconsin.

"Dr Treffert was elected president of the Society in 1979, a time of change and uncertainty for the profession. As president, he was a highly articulate spokesman for physicians and the public on a number of health issues. He argued for more active and humane treatment of the mentally ill; he continually prodded physicians to get more involved in the political process; and he exhorted the profession to put its own house in order by dealing with impaired or incompetent physicians.

"From 1980 to 1987 Dr Treffert was chairman of the board of the Society. Earl Thayer, former secretary-general manager of the Society, has called him a chief executive's dream for his rare understanding of the difference between policy and management and how the two need to mesh for an effective organization. He also demonstrated an ability to get things done while working behind the scenes, to get people to rally around him, to be in charge without ever appearing to be, and to know

when to go slow and when to go for broke.

"Dr Treffert's other accomplishments and public awards are numerous. He is a nationally recognized expert on Savant syndrome and on alcohol and other drug abuse issues. In 1971 he was honored as the Mental Health Man of the Year by the Wisconsin Mental Health Association. He was president of the Wisconsin Psychiatry Association from 1974 to 1976, and he has been active in mental health issues relating to Wisconsin's youth.

"Without Dr Treffert's leadership and commitment, many of the Society's most important projects would have gone undone. The continuing success of the Wisconsin Workshop on Health is a notable example.

"Darold Treffert's contributions, however, extend beyond his public roles. Anyone who has had the pleasure of working with him knows of his compassion, commitment and caring for other people. He has also taught us about mellowing, about getting our priorities straight and finding a purpose in life, and about seeing with the heart.

"For his many years of devotion and service to the science of medicine, to the physicians of the state and to the public, I am pleased to present this Director's Award to Dr Darold Treffert."■

Distinguished Service Award

Established in 1964, the Distinguished Service Award is given each year to a Wisconsin physician for outstanding contributions in the field of medical education. This year's recipient was Bradley G. Garber, MD, of Osseo.

In presenting the award to Dr Garber, Kenneth M. Viste, Jr, MD, SMS president, made the following remarks:

"Dr Garber has served on the Commission on Continuing Medical Education since 1972 and has chaired the Subcommittee on Accreditation since 1974. This important commission is responsible for all Society matters relating to the continuum of medical education throughout the state and for the accreditation of continuing medical education in hospitals and other institutions or organizations.

"During his tenure, Dr Garber participated in more than 50 site surveys for accreditation and attended more than 60 commission meetings and a like number of subcommittee meetings while maintaining a full-time practice in Osseo.

"Dr Brad, as he is affectionately called by his patients and friends, has lived a life of service to the people of Osseo. He went into general practice in 1962 after graduating from Ohio State University and completing an internship and residency at Luther Hospital in Eau Claire. Last year the people of Osseo held a celebration to honor him as he celebrated his silver jubilee.

"He has not only provided the best possible medical care to his patients, but he has also been active in a variety of civic leadership roles. He was very instrumental in the opening of a local cardiac care unit; he has taught classes in health education in the public schools for many years; and he has been a leader in the local Lion's Club, his church and in numerous special civic events.

"He is also a physical fitness buff. Two years ago he earned a black belt in taekwondo, and each year hosts Walkfest—a local physical fitness event—on his farm. Friends say that the beauty of his home reflects his closeness to nature and wildlife.

"Brad Garber also continues to set a fine example for continuing education by seeking out new intellectual challenges, and colleagues say he's really a student at heart. He often enrolls in seminars and classes on topics unrelated to his medical practice for the challenge and sense of intellectual achievement and growth. He is also actively involved in medical education through his instruction of medical students each summer in Osseo. Students say he teaches them all aspects of the profession—first the medical and then the business and political.

"Dr Garber undertook another challenge in March as he left his Osseo practice to join Luther Hospital in Eau Claire as an emergency room physician. Good luck to you, Dr Garber, as you begin your new career.

"Throughout his years of service, Dr Bradley Garber has demonstrated an unusually strong interest and fine capability in medical education, continuing education and accreditation and certification issues. For dedicated service to medicine and to the people of Wisconsin, I am pleased to present him with this Distinguished Service Award."■

Meritorious Service Award

Fourteen physicians who concluded terms of office on the Board of Directors and SMS committees and commissions and two employees who recently retired from the SMS were presented the Meritorious Service Award by President Kenneth M. Viste, Jr, MD. Dr Viste cited the recipients for their exceptional leadership and dedication to the State Medical Society and the health of Wisconsin citizens. They are:

Merlyn C.F. Lindert, MD, of Milwaukee, who served 26 years on the Editorial Board of the Wisconsin Medical Journal;

Edwin L. Overholt, MD, of La Crosse, serving nine years on the Commission on Continuing Medical Education, including two years as chairman;

Roland E. Herrington, MD, of Greenfield, for nine years as chairman of the Committee on Alcoholism and Other Drug Abuse;

John O. Simenstad, MD, of Osceola, serving 20 years as chairman of the Committee on Medicine, Religion and Ethics;

John P. Mullooly, MD, of Milwaukee, who served 17 years on the Committee on Medicine, Religion and Ethics;

Pauline M. Jackson, MD, of La Crosse, serving nine years on the

Committee on Mental Health, including four years as chairman;

Ralph F. Hudson, MD, of Eau Claire, for 22 years on the Committee on Safe Transportation;

Walter F. Smejkal, MD, Manitowoc, for 25 years on the Committee on Safe Transportation;

James C.H. Russell, MD, of Fort Atkinson, serving 30 years on the Committee on School Health, including 24 years as chairman;

Cyril M. Hetsko, MD, of Madison, who served nine years on the Board of Directors;

Jerome W. Fons, Jr, MD, Cudahy, serving seven years on the Board of Directors;

Glenn H. Franke, MD, Waukesha, serving three years on the Board of Directors;

Jung K. Park, MD, Wisconsin Rapids, for eight years on the Board of Directors;

C. William Freeby, MD, Appleton, serving four years on the Board of Directors;

Mary L. Angell, for 30 years of service to the *Wisconsin Medical Journal;* and

Mavis O. Minor for 24 years of service to the State Medical Society of Wisconsin in personnel administration. ■

Special Recognition Award

Five physicians who retired from service on an SMS commission or committee received the Special Recognition Award. They are:

Ronald J. Darling, MD, of Waukesha, who served 11 years on the Commission on Mediation and Peer Review;

John A. DeGiovanni, MD, of Prairie du Sac, for nine years on the Commission on Mediation and Peer Review;

Michael R. McCormick, MD, of Waukesha, for 10 years on the Commission on Mediation and Peer Review;

John E. Thompson, MD, of Nekoosa, who served nine years on the Physicians Alliance Commission; and

Elston L. Belknap, Jr, MD, of Madison, for 16 years on the Committee on Aging, Extended Care Facilities and Home Health Care. ■

Beaumont Lecture Award

"Cost Containment in Surgical Practice," was the title of the 1988 William Beaumont Memorial Lecture given by Ben Eiseman, MD. Dr Eiseman is a professor of surgery at the University of Colorado in Denver.

Established by the State Medical Society of Wisconsin in 1957, the William Beaumont Memorial Lecture is aimed at presenting to members of the Society distinguished medical scientists whose research and clinical experience may enrich the knowledge and skills of Wisconsin practitioners. The lecture is given each year during the surgery meeting of the State Medical Society to honor William Beaumont, a US Army surgeon who in the 1830s performed a series of experiments on digestion that laid the foundation for understanding the phenomenon.

Dr Eiseman received the award from Roger L. von Heimburg, MD, chairman of the Board of Directors of the SMS. The SMS Charitable, Educational and Scientific Foundation administers the Beaumont Award Fund. ■

Elvehjem Lecture Award

Horace K. Ivy, MD, of the Mayo Clinic in Rochester, Minn, presented the 1988 Elvehjem Memorial Lecture April 30 during the Internal Medicine Program at the SMS annual meeting. Dr Ivy's lecture was entitled "Thyroid Disease, Particularly in Older Patients."

The Elvehjem Memorial Lecture was established in 1962 to honor the memory of Conrad A. Elvehjem, PhD, the 13th president of the University of Wisconsin and an internationally recognized authority in biochemistry. His most famous scientific achievement and greatest contribution was the isolation of nicotinic acid, which led to the cure for human pellagra. The lecture is a project of the SMS Charitable, Educational and Scientific Foundation and is intended to perpetuate Dr Elvehjem's contribution to the health of Wisconsin's citizens and the continuing medical education of physicians. Kenneth I. Gold, MD, of Beloit, presented the Elvehjem Award to Dr Ivy during the spring meeting of the Wisconsin Society of Internal Medicine. ■

Houghton Award

The Houghton Award of the State Medical Society's Charitable, Educational and Scientific Foundation is presented each year to senior medical school students who demonstrate scholastic excellence, extracurricular achievement, and interest in medical organization. Winners receive a check for $250 and an engraved plaque, both of which are presented at the Society's annual meeting.

Recipients of the 1988 Houghton Award are Steven R. Hoer, a senior at the Medical College of Wisconsin in Milwaukee, and John M. Keggi, a senior at the University of Wisconsin Medical School in Madison.

In nominating Hoer for the award, Barbara Kirby, MD, until recently associate dean for academic affairs at the Medical College said, "It is clear from his academic performance that Steve beautifully blends the art and science of medicine and should make a superb physician." Among Hoer's many achievements, Dr Kirby cited as particularly significant his founding of the Medical College's Applicant Host Program. Through this program, medical students greet applicants at the airport, help orient them to the school, and provide housing the night before their admissions interviews.

Keggi, who is from Appleton, received his bachelor's degree from the University of Wisconsin–Madison. He is planning a residency in orthopedic surgery and has been an active member of both the State Medical Society of Wisconsin and the American Medical Association. ■

Wisconsin Medical Journal Writing Contest

During the past year, the *Wisconsin Medical Journal* sponsored a writing contest for medical students and residents. Intended as an annual event, this contest is meant to encourage and reward good science writing and to cultivate interest in the Society among students and residents. This year's winner of the resident writing contest was Gwen Martin for her paper entitled "Peritoneovenous Shunting for Malignant Ascites." Lance Longo won the student writing contest with his article "Medicine on Television: Fact, Fiction . . . or Both?"

During a House of Delegates session at the annual meeting, Richard D. Sautter, MD, medical editor of the *Journal,* presented the winners with a check for $500 and an engraved plaque. Both articles were published in the June issue of the *Wisconsin Medical Journal.*■

Fifty Year Club

Each year the State Medical Society of Wisconsin honors its members who have served their profession and patients for 50 years. This year 51 physicians were inducted into the Fifty Year Club at the Directors Dinner during the annual meeting in Milwaukee. Those who attended spent the evening greeting old friends and reminiscing about the practice of medicine in the good old days. Kenneth M. Viste, Jr, MD, SMS president, presented each inductee with a special certificate and club pin and congratulated each one on his or her entry into this distinguished group.

Physicians who entered the Fifty Year Club in 1988 are:

James A. Alston, MD, Waukesha
Carroll A. Bauer, MD, Phillips
Leo M. Boxer, MD, Fox Point
Lester P. Brillman, MD, Beloit
Richard J. Bryant, MD, Durand
Kenneth L. Carter, MD, Beloit
John F. Cary, MD, Milwaukee
G.P. Ferrazzano, MD, Clearwater, Fla
Lloyd L. Fifrick, MD, Milwaukee
James W. Fulton, MD, West Allis
Irwin E. Gaynon, MD, Whitefish Bay
Walter S. Giffin, MD, Largo, Fla
Vernon M. Griffin, MD, Mauston
David N. Goldstein, MD, Kenosha
Gretchen Guernsey, MD, La Crosse
William O. Hendrickson, MD, Woodruff
Howard C. High, MD, Milwaukee
John F. Holmes, MD, Milton
Jewel S. Huebner, MD, Oshkosh
John F. Imp, MD, Milwaukee
Sture A.M. Johnson, MD, Sun City, Ariz
Orville R. Kelley, MD, San Diego, Calif
Jules D. Levin, MD, Milwaukee
Dominic J. Martinetti, MD, Hurley
Robert E. McMahon, MD, La Crosse
Abraham Melamed, MD, Milwaukee
Jules O. Meyer, MD, Milwaukee
Jane M. Moir, MD, Oostburg
Louis Olsman, MD, Poway, Calif
George E. Oosterhous, MD, Madison
Thomas J. Pendergast, MD, Milwaukee
Herbert W. Pohle, MD, Milwaukee
John F. Poser, MD, Columbus
Rolf F. Poser, MD, Columbus
Harold Rand, MD, Milwaukee
Everett W. Reinardy, MD, Punta Gorda, Fla
John G. Russo, MD, Kaukauna
Anthony J. Sanfelippo, MD, Milwaukee
Irvin E. Schiek, Jr, MD, Rhinelander
Bert B. Schoenkerman, MD, Milwaukee
Edward G. Schott, MD, Sheboygan
Harold T. Schroeder, MD, Racine
Alois J. Sebesta, MD, Shawano
Frederick H. Smith, MD, Neenah
H. Gladys Spear, MD, Milwaukee
Mildred Stone, MD, Madison
Axel Trangsrud, MD, Milwaukee
James S. Vedder, MD, Marshfield
Edward W. Vetter, MD, Fond du Lac
John H. Wishart, MD, Eau Claire
Erie W. Wits, MD, Sun City Center, Fla.■

The Beaumont 500 Club

The Fort Crawford Medical Museum is unique among educational and cultural institutions in the Midwest and the nation. Far more than a museum, it stands as a tribute to Wisconsin's physicians who have dedicated their lives to ensuring the health of the state's citizens. The museum is also a singular tool for educating the public about the prevention and treatment of injury and disease, the nature of medical care, the value of the physician-patient relationship, and the importance of keeping one's health.

The Fort Crawford military hospital, which has been designated a national landmark, and the related museum are located in Prairie du Chien near the Mississippi River. On this site in the 1830s, Dr William Beaumont carried out his famous experiments on the physiology of digestion.

The actual planning for the museum began in the 1930s when the State Medical Society of Wisconsin placed a granite memorial near the crumbling remains of the second Fort Crawford, which had been abandoned in 1872. In the mid 1940s, the SMS House of Delegates endorsed furnishing the hospital building as a museum. The property was deeded to the SMS Charitable, Educational and Scientific Foundation in the 1950s, and the SMS approved the completion of the museum complex, known officially as the Museum of Medical Progress. In 1964 the Stovall Hall of Health was added, which provided additional exhibit space.

In 1981, the MMP Endowment Fund was established to provide financial support for the museum. Over the years more than 200,000 visitors have toured the museum, yet it continues to face financial hardship and is in need of frequent repair. The fund's directors have established a goal of $500,000 in order to secure the continued operation and maintenance of the complex.

The first 500 persons who contribute $1,000 or more to the MMP Endowment Fund will join a select

group known as the Beaumont 500 and will receive a specially designed Beaumont medallion. To date, 68 persons have joined the Beaumont 500 Club, and several more have pledged their support.

To further enhance the financial stability of the MMP Endowment Fund, the SMS Auxiliary has designated the Beaumont 500 Club as a challenge project. Each county auxiliary will pledge $1,000 over a specific time and challenge its county medical society to provide matching funds. Many auxiliaries and county medical societies have accepted this challenge, and the project is off to a successful start.

Through the contributions of the Beaumont 500, the Ft Crawford museum will continue to enlighten Wisconsin's citizens about the important people and events that have shaped Wisconsin medicine.

For more information about the Beaumont 500 Club, please contact Kristin Bjurstrom Krueger at the State Medical Society at 1-800-362-9080 or 608-257-6781.

Members

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W. Bruce Fye, MD
Pauline M. Jackson, MD
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SMS Resource Directory

Timely, accurate information is essential in our complex, rapidly changing medical environment. Information—when you need it—on scientific issues, legislative issues, and socioeconomic issues is available at your State Medical Society headquarters in Madison.

This SMS Resource Directory is provided as a brief reference guide to assist you in locating the resource person on the SMS staff who is best able to answer your questions on a wide variety of topics. Their pictures appear elsewhere in this issue of *WMJ*.

Simply call 1-800-362-9080 for immediate access to this valuable membership resource.

A

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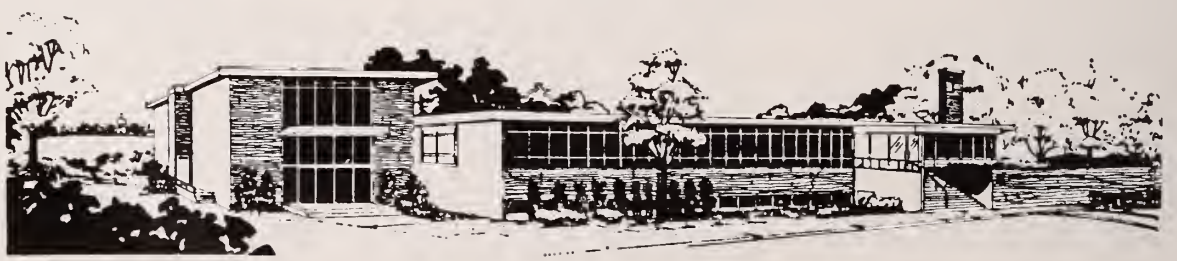

STATE MEDICAL SOCIETY OF WISCONSIN

330 East Lakeside Street—Madison, Wisconsin

The "Home" of the State Medical Society on the south shore of Lake Monona houses not only the Society's general administrative offices but also the Physicians Insurance Company of Wisconsin and the Visiting Nurses Service, the latter two by lease arrangement. The facility includes a Board of Directors room, other meeting rooms, and a dining room. A complete renovation of the interior is underway in a three-year program.

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Physician Referrals
Dane County . . . . . Jean Steele
Other Counties . . . . . Jim Lundberg/Joyce Pease
Political Action . . . . . Terry Hottenroth/Field Consultants
PPO . . . . . Frank Vogel
Practice Management . . . . . Lee Johnson
Practice Management Seminars . . . . . Karen Lord
Printing . . . . . Bill Guerten
Professional Liability (Legislative
Information and Related Matters) . . . . . Terry Hottenroth/Mark Adams
Professional Liability Insurance . . . . . Don Peterson/Charlie Sitkiewitz/Barb Kalupa
Property Management—SMS . . . . . Bill Wendle/Lee Johnson
PRO . . . . . Bernie Maroney/Trish Ramsay
Public Affairs Division . . . . . Terry Hottenroth
Public Health . . . . . Frank Vogel/Terry Hottenroth
Public Information . . . . . Ron Henrichs/Russell King
Public Relations . . . . . Ron Henrichs

R

Radio . . . . . Ron Henrichs/Kathryn Derene
Resident Physicians . . . . . Ron Henrichs
Risk Management . . . . . Mark Adams
Rural Health . . . . . Trish Ramsay/Deborah Wilke

S

SAVA (Small Area Variations Analysis) . . . . . Frank Vogel
Safe Transportation . . . . . Bernie Maroney/Maxine Gilbert
Savant Syndrome Information . . . . . Kristin Krueger
School Health . . . . . Ron Henrichs
Scientific Affairs . . . . . Bill Wendle
Second Opinions . . . . . Trish Ramsay/Bernie Maroney
Speakers
Scientific . . . . . Bill Wendle
Other . . . . . Ron Henrichs
Specialty Society Services . . . . . Lanny Hardy
Student Loans and Scholarships
Applications . . . . . Kristin Krueger
Repayments . . . . . Norma Swenson
SMS Services, Inc.
Accounts Receivable . . . . . Marcella Herfel/Kris Hensen
Accounts Payable . . . . . Kris Hensen
Association Management Services . . . . . Lanny Hardy/Jean Steele
Endorsed Programs . . . . . Noreen Krueger/Lee Johnson
General . . . . . Lee Johnson
Insurance Plans . . . . . Jan McChesney
Premiums . . . . . Jan McChesney
Super Rule Update . . . . . Trish Ramsay

T

Tax Problems . . . . . Bernie Maroney/Sally Wencel
Television . . . . . Ron Henrichs/Kathryn Derene
Title 18 (Medicare) . . . . . Trish Ramsay
Title 19 (Medicaid) . . . . . Trish Ramsay
Tourette Syndrome Physician Guides . . . . . Kathy Mohelnitzky

U

Utilization Review . . . . . Frank Vogel

W

WHCLIP (Wisconsin Health Care Liability
Insurance Plan) General Information . . . . . Mark Adams
Wisconsin Ambulatory Medical Care Survey . . . . Trish Ramsay
Wisconsin Association of
Senior Physicians (WASP) . . . . . Kristin Krueger
Wisconsin Medical Journal . . . . . Russell King/Marge Stafford
Wisconsin Workshop on Health . . . . . LaVerne Bartel
Wisconsin Peer Review Organization
(WIPRO) . . . . . Trish Ramsay/Bernie Maroney
WIPRO Audits . . . . . Trish Ramsay
WISPAC . . . . . Terry Hottenroth/Jackie Millar/Field Consultants
Women's Health Issues . . . . . Maxine Gilbert
Women Physicians . . . . . Maxine Gilbert
Workers Comp Program . . . . . Lee Johnson

Y

Young Physicians Section . . . . . Ron Henrichs

SMS—Public Affairs Division Field Consultants By County

DISTRICT 1
Lois Riley
1-414-271-4328

County Medical Societies
Kenosha
Milwaukee
Ozaukee
Racine
Sheboygan
Walworth
Washington
Waukesha

DISTRICT 2
Deborah Bowen Wilke
1-800-362-9080
1-608-257-6781

County Medical Societies
Columbia-Marquette-Adams
Dane
Dodge
Grant
Green
Green Lake-Waushara
Iowa
Jefferson
Juneau
Lafayette
Richland
Rock
Sauk

DISTRICT 3
Paul Markowski
1-800-362-9080
1-608-257-6781

County Medical Societies
Brown
Calumet
Door-Kewaunee
Fond du Lac
Forest
Langlade
Lincoln
Manitowoc
Marathon
Marinette-Florence
Oconto
Oneida-Vilas
Outagamie
Portage
Shawano
Waupaca
Winnebago
Wood

DISTRICT 4
Tom Stoebig
1-800-362-9080
1-608-257-6781

County Medical Societies
Ashland-Bayfield-Iron
Barron-Washburn-Burnett
Chippewa
Clark
Crawford
Douglas
Eau Claire-Dunn-Pepin
La Crosse
Monroe
Pierce-St. Croix
Polk
Price-Taylor
Rusk
Sawyer
Trempealeau-Jackson-Buffalo
Vernon

County Society Services
Toll Free: 1-800-362-9080
Regular: 1-608-257-6781

Dane County Medical Society
Madison Office . . . . . Lanny Hardy

Medical Society of Milwaukee County
Milwaukee Office
Mediation/Membership . . . . . Julie Leser (414-271-4328)
Physicians Alliance . . . . . Lois Riley (414-271-4328)

SMS Services, Inc.

INSURANCE SERVICES
Home Office—Madison
Don Peterson (608) 257-6781

District Managers

Charlie Sitkiewitz
Madison (608) 257-6781

Don Mulock
Milwaukee (414) 747-0919

ASSOCIATION MANAGEMENT SERVICES
Lanny Hardy
Madison (608) 257-6781

Services to Other Organizations

Toll Free: 1-800-362-9080
Regular: 1-608-257-6781

Wisconsin Academy
of Physician Assistants . . . . . Lanny Hardy/Jean Steele

Wisconsin Association of
Medical Directors . . . . . Lanny Hardy/Jean Steele

Wisconsin Chapter—American College of
Emergency Physicians . . . . . Lanny Hardy/Jean Steele

Wisconsin Clinic Managers Association . . . . . Lanny Hardy/
Jean Steele

Wisconsin Council of Child and Adolescent
Psychiatry . . . . . Lanny Hardy/Jean Steele

Wisconsin Homecare Organization . . . . . Lanny Hardy/
Jean Steele

Wisconsin Neurological Society . . . . . Lanny Hardy/
Jean Steele

Wisconsin Psychiatric Association . . . . . Lanny Hardy/
Jean Steele

Wisconsin Society of Oral and
Maxillofacial Surgery . . . . . Lanny Hardy/Jean Steele

SMS-Affiliated Organizations
Toll Free: 1-800-362-9080
Regular: 1-608-257-6781

Auxiliary of SMS . . . . . LaVerne Bartel

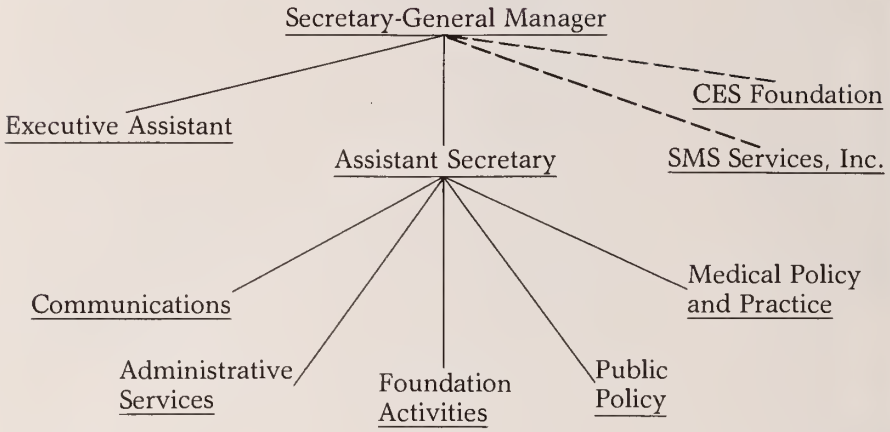
CES Foundation . . . . . Kristin Krueger

SMS Services, Inc. . . . . Lee Johnson

WISPAC (Wisconsin Physicians Political
Action Committee) . . . . . Terry Hottenroth/
Jackie Millar

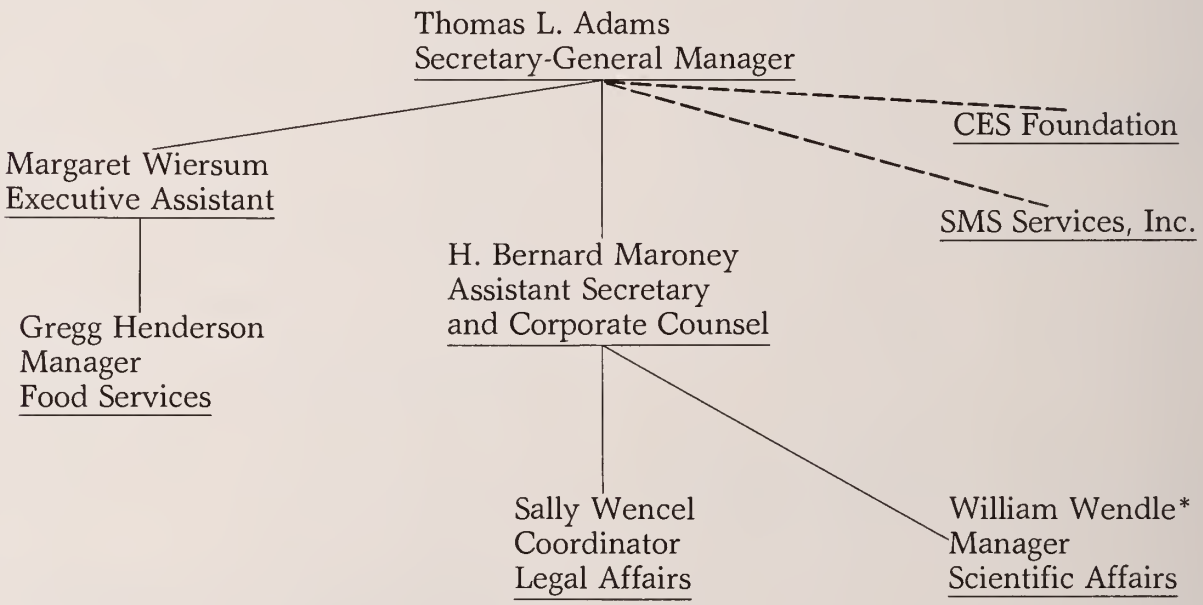
SMS Staff: 1988

Senior Management



Thomas L. Adams
Secretary-General Manager

Office of the Secretary



**Photos appear elsewhere in this section.*

H. Bernard Maroney
Assistant Secretary

Margaret Wiersum
Executive Secretary

Sally Wencel
Coordinator, Legal Affairs

Gregg Henderson
Food Service Manager

Maxine Gilbert
Administrative Assistant

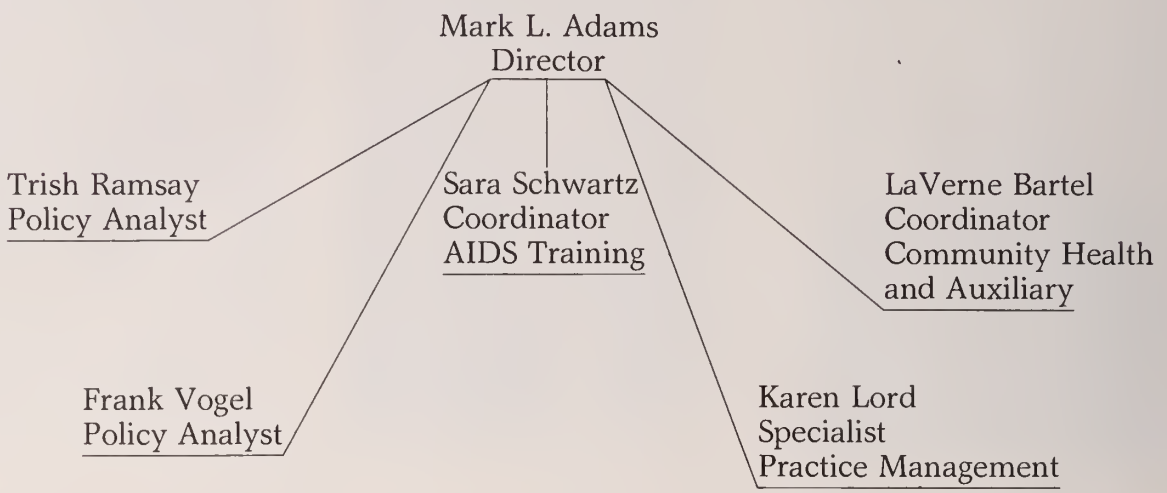
Julie Leser
Administrative Assistant

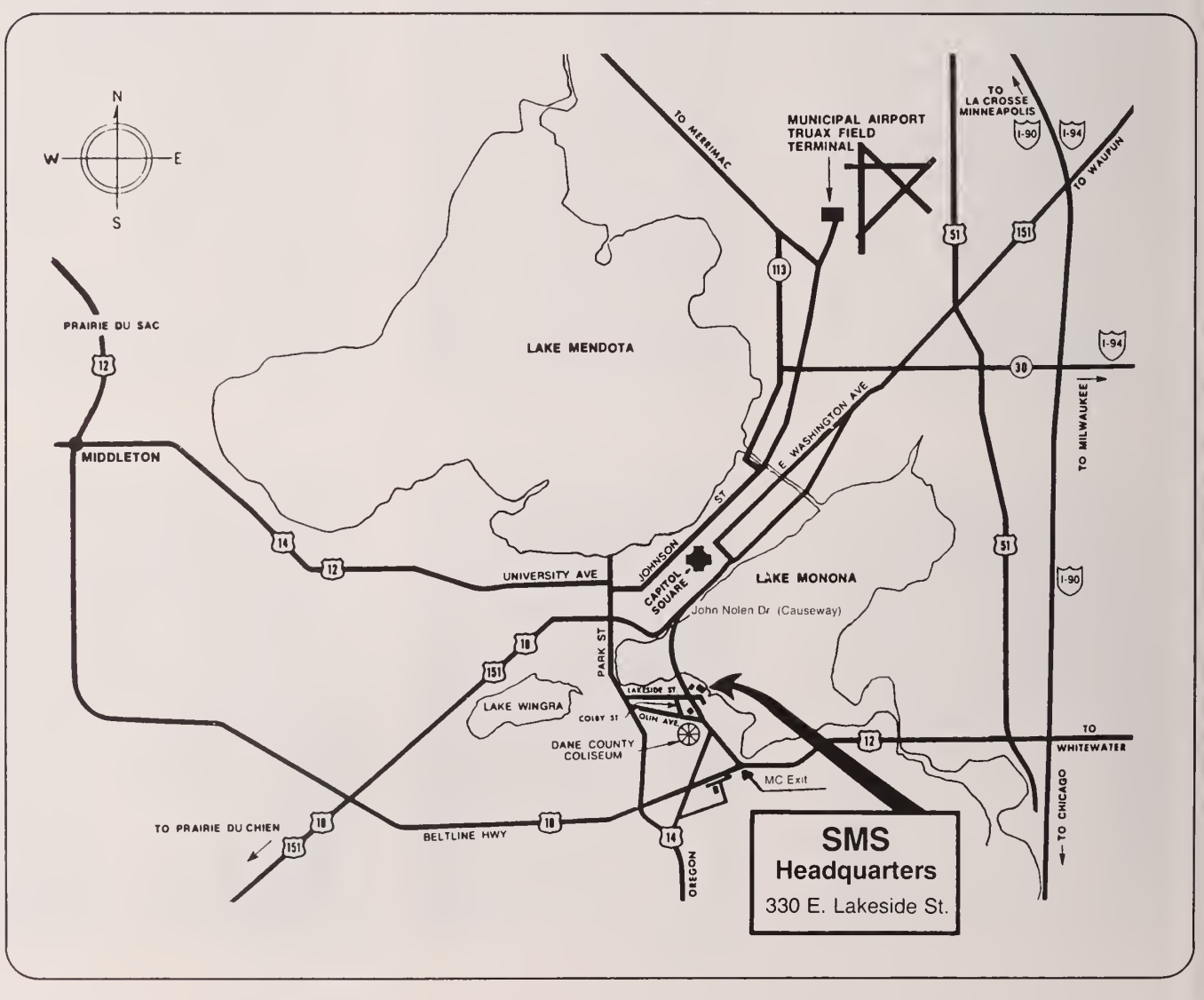
Mary Borland
Food Service Assistant

Terri Weaver
Secretary

Sonia Porter
Secretary

Division of Medical Policy and Practice





Mark Adams
Director

Trish Ramsay
Health Policy Analyst

Sara Schwartz
Coordinator, AIDS Training

LaVerne Bartel
Auxiliary/Community Health

Karen Lord
Practice Management Specialist

Francis Vogel
Health Policy Analyst

Jacqueline Millar
Administrative Assistant

Lisa Lawry
Secretary

Chris Long
Secretary

Division of Public Affairs

Theresa Hottenroth
Director

Deborah Bowen Wilke
Assistant Director

Lois Riley
Director
Political Education

Donald Lord
Manager
Governmental Relations

Medical Society Relations

Lois Riley
District 1
Representative

Deborah Bowen Wilke
District 2
Representative

Paul Markowski
District 3
Representative

Thomas Stoebig
District 4
Representative

Theresa Hottenroth
Director

Donald Lord
Manager, Governmental Relations

Lois Riley
Director, Political Education
District 1 Representative

Deborah Bowen Wilke
Assistant Director
District 2 Representative

Paul Markowski
District 3 Representative

Thomas Stoebig
District 4 Representative

Karen Butler
Secretary

Division of Foundation Activities

Kristin Bjurstrom Krueger
Director

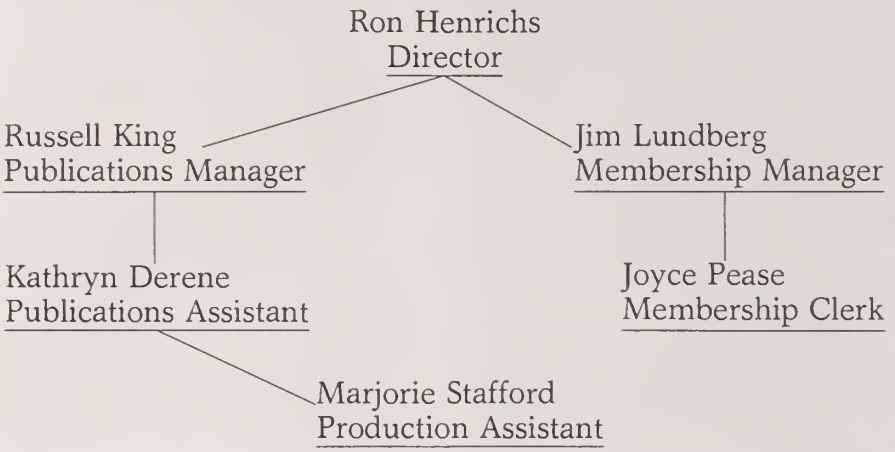
Fort Crawford
Medical Museum
Prairie du Chien

Charitable, Educational
and Scientific Foundation

Kristin Bjurstrom Krueger
Director

Kathleen Mohelnitzky
Administrative Assistant

Division of Communications



Ron Henrichs
Director

Russell King
Publications Manager

Kathryn Derene
Publications Assistant

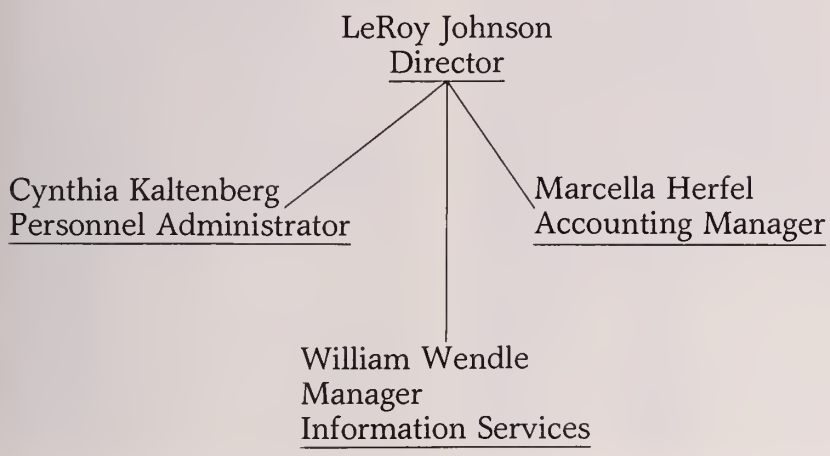
James Lundberg
Membership Manager

Marjorie Stafford
Production Assistant

Mary Strohm
Secretary

Joyce Pease
Membership Clerk

Division of Administrative Services



LeRoy Johnson
Director

Cynthia Kaltenberg
Personnel Administrator

Marcella Herfel
Accounting Manager

William Wendle
Manager, Information Services

Noreen Krueger
Administrative Assistant

Stefanie Beam
Personnel Assistant

Vicki Meyer
Word Processing Operator

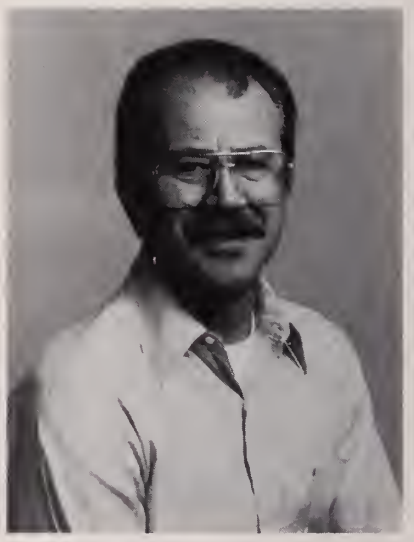
Karen Cramer
Receptionist

Rick Koffarnus
Senior Accounting Clerk

Kristine Hensen
Senior Accounting Clerk

Norma Swenson
Accounting Clerk

Elaine Bradley
Accounting Clerk



Donald Temby
Facilities Engineer

John Boxrucker
Maintenance Lead

Michael Williams
Maintenance Assistant

Andrew Johnson
Maintenance Helper

SMS Services, Inc.

LeRoy Johnson*
Executive Vice President

William Wendle*
Manager
Printing and Mail Services

Noreen Krueger*
Administrative Assistant

Donald Peterson
Manager
Insurance Agency

Lanny Hardy
Manager
Association Management Services

William Guerten
Officer Services Manager

Daniel McClure
Lead Machine Operator

David Conner
Press Operator

Marie Shipley
Lead Mail Clerk

Mary Belz
Mail Clerk

Scott Selgren
Material Handler

**Photos appear elsewhere in this section.*

Donald Peterson
Insurance Agency Manager

Donald Mulock
District Manager

Charles Sitkiewitz
District Manager

Janet McChesney
Insurance Coordinator

Barbara Kalupa
Administrative Coordinator

Alice Ballweg
Computer Coordinator

Heidi Schmiedlin
Account Clerk

Gail Schwoegler
Clerk Typist

Susan Williamson
District Secretary

Sandra Lewin
District Typist

Lanny Hardy
Manager, Association Services

Jean Steele
Administrative Assistant

Tami Karls
Secretary

CHILD'S PLAY IS NOT ENOUGH.

Surveys indicote thot mony porents overestimote the physicol fitness of their children becouse they oppeor so octive. The fact is, to be physicolly fit, children need one to two *hours* of vigoraus exercise each day.

Whot con you do to ensure thot your children get enaugh exercise? Try the following:

- Discuss your child's overoll physicol fitness with yaur school's Physicol Educotian teocher.
- Moke o conscious effort to monitor the type ond omount of exercise your child gets both in ond out of school.
- Be oware of your child's weight in comporison to medically accepted norms for his ar her age and size.

With the right omount of doily exercise, teenogers ond children of oll oges will get the mast fram school . . . ond ploy.

For more information, write to: Fitness, Dept. 84, Washington, DC 20001.

Fitness is feeling GREAT!

The President's Council on Physical Fitness and Sports

Mediation and peer review services

PHYSICIANS ARE QUITE aware that medical care is a very personal matter, each patient being different from all others, and each responding differently to a given treatment approach. Medicine is not an exact science, and at times physicians and patients may not agree on what is proper care. Misunderstandings do arise about what the physician hopes to accomplish and what the patient expects. When this occurs, it is important that the patient discuss with the physician any questions about the medical care received. However, if they are not resolved, the State Medical Society provides a means for resolving these differences.

The Society's Commission on Mediation and Peer Review receives, investigates, and resolves complaints and inquiries from patients and others concerning Wisconsin physicians. The Commission's standard of judgment is what constitutes good medical care. Physicians, too, may benefit from Commission efforts to mediate differences between themselves.

Many complaints and questions received by State Medical Society staff are resolved by telephone. However, by protocol, only written complaints will be considered by the Commission. If all affected parties reside within the boundaries of a single county medical society, that society may assume jurisdiction of the complaint. If it does, the complaint will be transferred to the county medical society for investigation and resolution.

STATE DEPARTMENT OF REGULATION & LICENSING

Physician licensure verification procedure

The Department of Regulation & Licensing offers several avenues available to verify the licensure of medical professionals.

A. Purchase of the Department's current master printout of licensees (name, address, and license number) at a cost of about $60 for all licensees of the Medical Examining Board. Contact the Department's Renewal Section at (608) 266-0627 for further information and ordering.

B. Purchase of the Department's directory of Medical Board licensees which is current up to March 1986, contains no license numbers, and costs $6.30.

C. Checking, at the physician's facility, the current registration card of all Medical Board licensees. That certificate, stamped "valid to December 1987" is the physician's proof of being currently registered with the Medical Examining Board.

D. Writing or calling the Medical Board office when the following is true:

1. Applicant for staff privileges is not listed in the printout or directory.
2. Applicant for staff privileges cannot produce a current registration card.
3. Applicant is a new licensee in Wisconsin.
4. A person has good reason to believe the Medical Examining Board has disciplined the licensee and vertification of that fact is desired.

Physicians who have been members of a hospital or clinic medical staff for a number of years will be expected to show their license "renewal card" every two years to the staff.

A physician experiencing no problems on a medical staff, having a current renewal card, and not listed in the *Digest of Rules and Discipline* will not show up as a problem on the Department's records.

The Department of Regulation & Licensing and the Medical Examining Board have told the State Medical Society that they wish to assure effective regulation of the profession to the citizens of Wisconsin and, therefore, are most anxious to assist physicians in the verification process.■

Physician re-registration

EVERY TWO YEARS physicians are required to re-register their license. As a part of this process physicians are required to attest to their having attained 30 hours of Category I Credit Hours of the Physician's Recognition Award of the AMA.

This requirement is subject to audit by the State Medical Examining Board. In this case physicians would be required to prove their attendance at continuing medical education programs that would grant them at least 30 hours of Category I Credit Hours in the previous two-year period.

Currently physicians are licensed for 1986 and 1987 and will be next required to attest to CME with re-registration forms mailed late in 1987 for their 1988–1989 license. Physicians are reminded to let the Medical Examining Board know of any address change (the post office only forwards for a six-month period). All fees associated with re-registration must be received by the Medical Examining Board by December 31 of the year re-registration occurs.■

A Protocol Manual was developed by the Commission on Mediation and Peer Review and approved by the Society's Board of Directors for conducting resolution of patient complaints, employing peer review mechanisms to test physician practice patterns, and responding to inquiries or requests for action regarding impaired physicians. The Protocol Manual was designed to accommodate informal disposition of minor and uncomplicated complaints as well as complex and serious matters which may involve due process, patient or physician appeals, proposed disciplinary actions, and Board of Directors consideration of continuance of a physician's State Medical Society membership. The Protocol Manual is available upon request.

Certain complaints received by the Commission are evaluated by subcommittees whose members submit reports and recommended resolutions to the Commission Chairman. Frequently these subcommittee conclusions are transmitted to the subject physicians, and as appropriate, to complainants. All subcommittee activities are reported to the Commission. Matters of a more serious nature require additional utilization of the Protocol Manual as necessary.

The Commission on Mediation and Peer Review offers peer review services to private and governmental organizations and to physicians, including utilization review, appropriateness of patient care, and quality assurance. Although it is empowered to initiate disciplinary action, the Commission's most valuable peer review benefits have been educational, judging from physicians' expressed appreciation for the Commission's consultation in matters of proper patient care.

The Commission maintains purview over the Statewide Impaired Physician Program (discussed elsewhere in this issue) and continues its interest in the Coordinating Council on Physician Impairment of the State Medical Society and the Medical Examining Board. The Commission participates in the Medicaid Medical Audit Committee under contract between the State Medical Society and the Wisconsin Department of Health and Social Services.

The Commission also is available to assist SMS members by "reviewing the reviewers." Commission members will review cases submitted by physicians who are the subject of Medicare or Medicaid reviews to provide an independent assessment of the appropriateness of care provided. In those instances where the Commission disagrees with a WIPRO or other review organization finding, the Commission will provide the physician with independent medical opinion in any further action taken by the review agencies.■

Statewide Impaired Physician Program

THE STATEWIDE IMPAIRED Physician Program functions under the purview of the Commission on Mediation and Peer Review although its activities are managed by a six-member Managing Committee. The program follows a protocol which guides the general handling of inquiries or concerns regarding identified impaired physicians. Available to members and nonmembers alike, the program offers education, identification, assessment, and compassionate intervention. The program refers patients to acceptable facilities for evaluation or treatment and monitors a two-year followup after completion of initial therapy.

Through the Impaired Physician Program a number of physicians have been encouraged by compassionate colleagues to enter structured rehabilitation. However, many more Wisconsin physicians need the Program's assistance because they are unable to assist themselves as they lose their battles against alcohol or other chemical substances, or who suffer from emotional illness or senility.

Experience to date in Wisconsin and elsewhere provides convincing evidence that physician impairment is substantial, but its degree is unknown beyond what is identified and intervened. Most of the literature on the subject contends that from ten to fourteen percent of practicing physicians have difficulty with alcohol and drugs. Some research suggests that one in ten physicians during a lifetime will abuse alcohol in professional circumstances so as to be identified as "impaired."

Unfortunately, many people in a position to observe and identify impaired physicians do not know what to do when they perceive a specific problem, nor do they realize that help is available from organized programs. Furthermore, individuals such as medical staff members, hospital administrators, and others are reluctant to report a physician to an organized program. Their initial reaction is not to get involved, or to conclude that the problem can be handled by someone else in some other manner. This attitude often results in delayed intervention and treatment or in passive action which ultimately fails. Still others who might otherwise report an impaired physician may seek legal advice, only to be told by their lawyers to be noncommittal and to respond only to a subpoena.

Such advice could be a deterrent to early intervention.

Current techniques of identification, intervention, assessment, treatment, and followup of impaired physicians are not well known in the medical community. Physicians are not generally adequately trained or skilled in identification, diagnosis, and treatment of patients with chemical dependency. As a result few are able to respond adequately when they accept an impaired physician as a patient.

It was certain from the beginning that the Program's efforts would be inadequate to the needs of that day and of future days. Thus, in 1982 the Board of Directors approved expansion of the Program with financing from the State Medical Society and other organizations. This improved program created the Managing Committee and established an ambitious timetable of education in awareness and of plans to inform Wisconsin physicians about Program services. However, as stated above, many more Wisconsin physicians need the Program's assistance. The Program will not reach those physicians without substantial and continuing attention. The capabilities of interested colleagues to "spread the word" are most limited.

Thus, through the Society's Commission on Mediation and Peer Review report to the 1986 House of Delegates, a major objective for 1986-87 was to "enable the Statewide Impaired Physician Program to greatly increase its ability to discover, intervene, and assist impaired physicians, and to improve physician awareness of the level of impairment through employment of a part-time Medical Director and necessary assistant."

Thus, through efforts of the Managing Committee, the SMS Board of Directors approved the concept of contracting with a part-time medical director to provide continuous program leadership and activity. And, at the 1988 Annual Meeting, the SMS House of Delegates adopted the Board's recommendation and, to fund the position, approved a $15 dues increase for 1989.

Meanwhile the present program implements the following:

PHASE I: Education and Prevention

Target individuals and groups are educated to an understanding of chemical dependency among physicians. They are informed of symptoms of impairment; techniques of early identification and prevention; and resources available for, identification, assessment, intervention, and treatment; and social, financial, legal, and other problems associated with impairment.

A. Primary Target Groups being reached in education and prevention efforts are:

1. Physicians: Meetings of hospital medical staffs, county medical societies, regional or statewide continuing medical education, and accredited seminars, *eg,* at the SMS Annual Meeting or specialty societies.
2. Hospital Personnel: Hospital administrators and medical directors, chiefs of medical staffs, hospital boards of trustees, directors of nursing and pharmacy and others, *eg,* anesthetists and technicians.

   Consultation for medical staff officers on establishing effective impaired physician committees or programs in hospitals.
3. Pharmacists, Nurses, and Nursing Home Administrators: Lectures at association meetings or in combination with physician and hospital personnel meetings.
4. Spouses and Families of Physicians: Educational material available at state and county medical society and auxiliary meetings.
5. Legal Profession: Urge lawyers, whose state association has its own impaired lawyers program, to encourage their physician clients to utilize organized medicine's voluntary impaired physician programs when perceived needs arise.

B. Teaching Staff for Educational and Prevention Phase

Teaching staff presents educational and prevention programs to the various target groups. The physician team approach is employed, at least one of whom is recovering from alcohol or other chemical dependency.

C. Literature is available to assist in an understanding of the disease of chemical dependency and to explain intervention, treatment, and followup resources.

PHASE II: Intervention and Treatment

Successful impaired physician programs include the availability statewide of "physician interveners" able to perform compassionate colleague-to-colleague contact with physicians who have been identified as impaired.

Approximately 35 physicians from throughout Wisconsin have been trained and are available to meet with and urge impaired colleagues to leave medical practice and to enter suitable programs for evaluation and treatment. Interveners act as teams. At least one intervener is either expert in,

Persons interested in the Impaired Physician Program may call 608/257-6781 or toll-free in Wisconsin: 1-800-362-9080 and explain their concern to John LaBissoniere, Sally Wencel, or H B Maroney of the State Medical Society staff. The caller's identity will be kept in complete confidence.

or has personal experience with, the impairment of concern. The initial intervention with an impaired physician is always a compassionate encounter. The Wisconsin program has no interest in the punitive or coercive approach until all benevolent measures have been exhausted. An intervener's interests are the personal wellbeing of a colleague and quality of healthcare for patients.

The Impaired Physician Program adheres to the policy that satisfactory recovery from chemical dependency can only be realized through a monitored two-year recovery period. It considers the two-year "after hospitalization" to be a critical component in assuring continued recovery.

PHASE III: Benevolent Assistance

The Statewide Impaired Physician Program finds that in addition to burdens of impairment, some physicians are unable financially to pay the cost of inpatient care. By estimate at least ten percent of Wisconsin impaired physicians either have no health insurance coverage or have coverage which is inadequate for the costs of inpatient care. Some have been ill for so long a period that their financial resources essentially have been depleted. About ten percent of the charges for rehabilitation of such physicians go unpaid. For twenty percent of impaired physicians, residence and treatment in "recovery homes" (average of three months at a cost of $1,500 per month) is essential for completion of the two-year recovery program. Although adequately funded to date, no long-term provision has been established to allow realization of the program commitment to a two-year recovery program.

With approval of the Boards of Directors of the State Medical Society and the CES Foundation, the Impaired Physician Program established a Physicians Benevolent Assistance Fund accomplished through pledges to the CES Foundation earmarked for the Benevolent Assistance Fund and payable over a two-year period. The fund appeal among members of the State Medical Society and Wisconsin hospitals was designed to develop a fund of $150,000 for low-interest loans for physicians who potentially can repay them after completing the inpatient phase and returning to medical practice.

* * *

The State Medical Society program maintains formal linkage with the Wisconsin Medical Examining Board through the Coordinating Council on Physician Impairment. The Council consists of three physicians representing the State Medical Society and three members of the Medical Examining Board. The Council establishes guidelines for the Statewide Program and coordinates activities so that appropriate information is shared and Council action can be taken in the event a physician fails to respond to treatment or refuses to enter rehabilitation. The Council may refer a physician to the MEB in an instance where the health of the public may be jeopardized. The Council presents a desirable balance of concerns and interests between the

HCFA 1500 HEALTH INSURANCE CLAIM FORMS—Wisconsin-approved or National Format—can be ordered direct from SMS Services

- Wisconsin Format approved by DHSS and EDS Federal for Wisconsin Medical Assistance Program (WMAP) claims.
- National Format approved for Medicare billing.
- Accepted by all major insurance carriers.
- Both versions available in one- or two-part form.
- Forms will be shipped to you within 48 hours after order received.

Place your order with SMS Services, Inc, 330 East Lakeside Street, PO Box 1109, Madison, Wisconsin 53701; or phone (608) 257-6781 or toll-free in Wisconsin (800) 362-9080.

voluntary assistance program of organized medicine and the state's statutory licensing and disciplinary body. Thus the Council is an appropriate step in the reporting process if necessary during attempts at physician rehabilitation where difficulty may be encountered.

Any responsible person concerned that a physician may suffer from an impairment may write to the Society or call 608/257-6781 in Madison or 1-800-362-9080 in Wisconsin. Strict confidentiality is assured. Staff assigned to receive information will consult with the Managing Committee chairman for guidance and early action. All information is evaluated for accuracy. When it is determined that a potential problem exists, an intervener team is recruited to meet with the involved physician. From that point the process evolves which should assist the physician to recognize the impairment and to accept a treatment plan leading to recovery and a return to a successful practice.■

Status report on Medical Mediation Panels

The enactment of Special Session Assembly Bill 4, in May 1986, brought substantial changes in the way medical liability cases are handled in Wisconsin. The Patients Compensation Panels were replaced with a mandatory mediation system. The goals of the new mediation system included:

- speedy resolution of disputes
- less costly resolution of disputes
- weeding out non-meritorious claims
- promoting settlement of meritorious claims, and
- providing a non-adversarial approach to dispute resolution.

All malpractice claims filed must now go through mediation prior to any court action. Mediation is conducted by a panel appointed by the administrator, consisting of an attorney, a physician and a public member. All deliberations of the panel are informal and are not admissable in court, since strict rules of evidence and procedure are not used.

The current administrator of the Medical Mediation Panels, Randy Sproule, completed a preliminary study of the first 250 cases that proceeded through the Mediation Panel system since its inception on Sept 1, 1986. He found that 59 cases have been disposed of—22 cases that were settled at mediation and 37 cases that were not filed in circuit court and the statute of limitations has passed.

Summary

Settled at mediation 9%
Not settled, not filed in court 15%
—statute of limitations expired
Not settled, not filed in court 7%
—statute of limitations not expired
Filed in court but mediation served constructive purpose 32%

Breakdown by settlement category and amount:

A. Cases settled—24
Pro se (Plaintiff represents self) 4
$10,000 or less 17
$10,000 to $50,000 5
More than $50,000 2

B. Cases not settled, not filed, statute of limitations expired—28
$50,000 or less 14
$50,000 to $100,000 2
More than $100,000 12

C. Cases where claimant seeking $25,000 or less—39
Settled 8
Not settled, not filed expired 9
Not settled, not filed not expired 9
Filed, constructive 6
Filed, not constructive 7

In summary, Sproule said, "Twenty-seven percent of the cases that have proceeded through mediation have been resolved within 90 days and without court action. Mediation has served a constructive purpose in 30% of the remaining cases. The Mediation Panels are not the panacea for the problem of spiraling medical malpractice insurance premiums. Indeed, there is no singular panacea. Nor is the mediation format or the administration thereof without flaws. The statistics show, however, that the panels are, for the most part, accomplishing the goals for which they were created. The next step is to address those cases and problems which the panels were not designed to address."

Physicians wishing further information on the Mediation Panels may contact the SMS Division of Medical Policy and Practice.■

Life is short . . . Art is long . . . Experience is difficult

The Charitable, Educational and Scientific Foundation

. . . was chartered by the State Medical Society of Wisconsin in 1955 as a private, nonprofit, nonstock corporation to enable physicians and other friends of the profession to support, through gifts and grants, projects vitally affecting scientific medicine and public health. The Foundation's scope of interest has grown in the three decades since its establishment, with increased volume of financial contributions for support of a broad spectrum of programs affecting medical and health-care needs in the State of Wisconsin.

All of its activities have been made possible through the generous gifts, bequests, and trusts of concerned and interested friends of medicine and better health.

The character of the medical profession shapes not only its own destiny but also has profound influence on the health and well-being of all the people of Wisconsin. This character finds its root in the centuries-old belief that individual freedom and well-being hinge on people helping themselves and one another. The State Medical Society of Wisconsin has reflected this spirit for nearly 150 years in its activities and services to the public and its member physicians.

The record of things accomplished in the first 30 years of the CES Foundation spells very substantial achievement. The future holds an endless array of opportunity and challenge.

BENEVOLENT ASSISTANCE. The CES Foundation is ever sensitive to the personal human needs of people who are the victims of adversity. Although the Foundation's capacity in dollars has been limited, it has often been able to arouse the spirit of caring among physicians and the public when special needs arise. Assistance is looked at as an investment in the future and not as charity.

Principal among its benevolent activities has been aid to physicians and their families made destitute by illness or injury. The largest of these benevolent efforts is the program of support for the state's two medical schools through contributions to the CESF-American Medical Association Educational Research Fund (AMA-ERF). This activity is under the leadership of the Auxiliary to the State Medical Society and its numerous county auxiliaries. Annually, their efforts result in contributions of approximately $20,000. Since 1955, Wisconsin's medical schools have received more than $395,000 in no-strings-attached contributions through this source.

EDUCATION. Postgraduate teaching programs are a major thrust of the Foundation. With CES Foundation support, the Medical Society's program of accreditation of continuing medical education, initiated in 1976, goes forward with increasing success. This effort now has accredited continuing education programing in 56 hospitals, 23 specialty societies and one county medical society. This effort has greatly expanded the availability of quality postgraduate learning opportunities for Wisconsin physicians and allied health personnel.

A **Speakers Service** is operated through the Foundation to provide county medical societies with scientific programing, especially those societies which are smaller or more distant from medical school centers.

Funding from the Foundation's **Barbara Scott Maroney Memorial Fund for Research on Diabetes** supports special research projects, summer camp scholarships for diabetic children, publication of scientific articles or presentation of scientific speakers on the subject.

Pursuant to our ideals and the belief in higher education, the Foundation makes available grants to high school teachers in Wisconsin through the **Postgraduate Workshop for the Basic Sciences,** to develop innovative science curriculums in the schools. The goals for this program are to provide a format for continuing education for high school teachers, enrich current science curriculums used in the state, provide resource materials and laboratory equipment to the high schools, and to stimulate student interest in science and expose them to wide varieties of science-related careers.

Annually, the CES Foundation recognizes outstanding achievements in student science research by high school and middle school students in Wisconsin through contributions for awards to the **Wisconsin Science Congress** and the **Wisconsin Science Olympiad.**

The State Medical Society's **25th Annual Workshop on Health,** a health education program for high school students, featured such topics as anorexia nervosa, eating disorders, sexually transmitted diseases, teen suicide, alcohol and drug abuse, and wellness. In the ever-popular program, the most recent conference featured world diving champion Greg Louganis and addressed the issue of "Reaching Your Potential."

STUDENT LOANS, GRANTS, AND SCHOLARSHIPS. One of the most important activities of the CES Foundation is the Student Loan Program. Established in 1955, the Foundation's General Student Loan Fund is designed to assist the needy, deserving students preparing for careers in medicine, dentistry, pharmacy, nursing, and other allied health fields. These long-term loans are interest free until after the student's graduation. Personnel in the financial aids departments of Wisconsin's schools cooperate with the Foundation in identifying needy and deserving students. Students enrolled in Wisconsin schools are eligible for Foundation loans. The General Student Loan Fund is supported by general contri-

butions earmarked for student loans.

In these inflationary times, many young men and women can achieve their medical careers only because of the availability of large-dollar, low-interest loans. In fact, the average medical student today can anticipate graduating with debt obligations ranging from $50,000 to $75,000.

In 1987, the Board of Directors of the CES Foundation met to amend the student loan program. The following is the revised student loan program which began operation Jan 1, 1988.

General eligibility requirements

A student must:

- be a resident of Wisconsin
- be admitted to either the University of Wisconsin Medical School or the Medical College of Wisconsin, (in the case of medical students) or an accredited Wisconsin school (in the case of other allied health professions).
- demonstrate financial need as determined by the criteria from the financial aids office of the individual institution
- maintain satisfactory academic progress
- be enrolled on a full-time basis
- meet the eligibility requirements of each of the loan fund programs
- not be in default on any educational loan, show an unwillingness to repay any educational loan or owe any refund on a grant or loan.

Terms

The CES Foundation Student Loan Program is designed to meet a portion of the deficit in the student's budget after aid has been received from the institution through other sources. The Foundation loans are designed to address the unmet need requirements of the student. Unmet need is defined as: the difference between the original "demonstrated need" figure for the academic year, and the amount of aid received to meet that need.

Accordingly, applications for all loans granted by the Foundation must be submitted annually on the basis of financial need. Applications for financial aid should be submitted between April 1 and May 31 for the following academic year. If, however, under emergency or unusual circumstances, funds are required at a later date and upon concurrence of the financial aids office, consideration will be given to applications received during other time periods. Applications must first be reviewed by the financial aids offices of the applicants institution and be accompanied by a recommendation for aid by the institution. The final decision will rest with the Foundation.

Loans to students are granted only on the basis of the degree of financial need as established by the school and only to the extent of available funds. Funds will be awarded in an amount up to $2,500 per academic year for junior and senior applicants with no prior CESF loans and $750 per academic year for freshmen and sophomore students. At no time however, will the loan aggregate be more than $5,000. Students being granted funding for the following academic year will be notified of such by mail not later than July 15th of each year. Disbursements for the academic year will be made on or about August 1.

Interest and repayments

Loans from the CES Foundation Student Loan Program will be interest free until graduation. At that time, simple interest shall accrue beginning on July 1, at a rate to be determined on July 1 after the graduation date. Repayment may be deferred for a period of up to four years for those students continuing in graduate studies, internships or residencies.

Interest shall be suspended during any period, not exceeding five years, in which the undersigned is on temporary active duty with the armed forces of the United States. The Foundation shall however, consider the loan due and payable on July 1, four years from the original graduation date, unless a deferred payment arrangement is made. Deferment requests must be made in writing to the CES Foundation 30 days prior to July 1 of the year of graduation. Loan recipients will be required to sign a deferred loan repayment form at that time.

Should the student fail to graduate or default on any of the eligibility requirements, the loan(s) will be considered payable in full. If the recipient does not have funds to cover repayment, he or she is expected to secure a loan from a commercial institution. If the recipient cannot obtain such funds, the Foundation may at its discretion, renegotiate the loan and provide for repayment at a rate calculated on a factor of the prime rate.

A borrower will be considered to be in default if he or she fails to: 1) make an installment payment when due; 2) submit deferment forms in a timely manner; or 3) comply with other terms of the loan contract.

Payments are due on the 1st day of the month for each calendar quarter. Payments not received by the 15th day of the month in which payment is due, will receive a late fee assessment of $10.

Repayments will be applied first to accumulated interest, late fees, and lastly to principal.

The maximum repayment period is 7 years. The Foundation bills on a quarterly basis and the minimum annual repayment is 14.28% of the amount borrowed plus interest.

The borrower agrees to be governed at all times by the Wisconsin Consumer Act with respect to all aspects of the transaction. The borrower may, at his or her option, and without penalty, prepay this loan in full or in part at any time. It is the responsibility of the loanee to advise the lender of any change in the address.

Although the Foundation's primary emphasis is on loans, some outright scholarships and grants are made to fulfill the wishes of some donors and the needs of certain potential recipients. These special health career student loan and scholarship funds are administered by the Foundation according to the wishes of the individual or organization establishing and supporting the fund.

For example, a county medical society auxiliary may make an original endowment to the CES Foundation to establish a student loan or scholarship fund in the county auxiliary's name. The county auxiliary, as the

benefactor may work with the Foundation to determine what restrictions, if any, are to be placed on the loans. Such restrictions may include residency requirements, career specifications, educational facility, limitation on year of study, and dollar amounts.

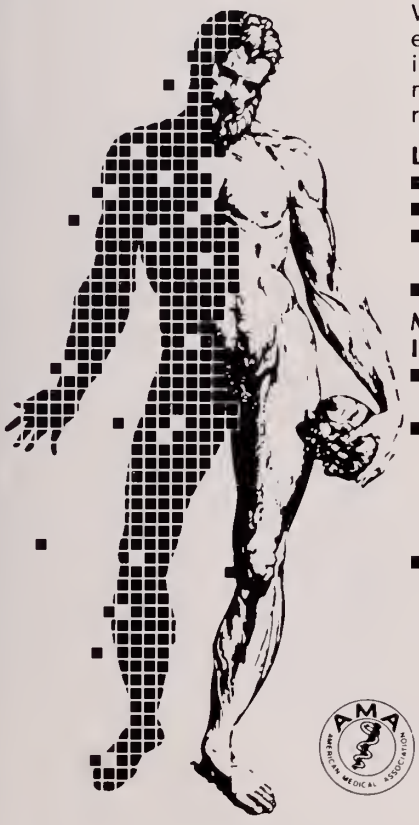
In establishing a special student loan or scholarship fund with the CES Foundation, the following point should be considered:

- Direct expenses incurred by the Foundation in administering the Fund will be charged to the Fund. (At the present time, by action of the Board of Directors, all Funds are charged an administrative fee equal to 25% of all income earned by the Fund on an annual basis.)
- In the event it is mutually determined that the purpose for which the special loan or scholarship fund was established no longer exists, the remainder of the Fund will be turned over to the Board of Trustees of the CES Foundation to use for other charitable, educational and scientific purposes.
- The Foundation may invest and reinvest assets of the Fund in accordance with prudent investment policies, and any interest or appreciation earned by such investments will accrue to the Fund.
- The Foundation may, at its discretion accept additional contributions to the Fund, accept accelerated payments of obligations to the Fund, waive repayment in hardship cases, and increase or decrease rates of interest as the demands for loans may dictate.
- The decision to approve individual loan applications, amount of loan, and terms of repayment will be made only by the CES Foundation and will be based on the need demonstrated and availability of funds.
- Applications will be accepted and considered without regard to race, creed, color or national origin.
- Application blanks may be procured from the CES Foundation, (330 E Lakeside St, Madison, WI 53715), the benefactor, or the college financial aids office.
- The CES Foundation furnishes an annual accounting to the benefactor or sponsoring organization.

To inquire how you or your organization can establish a special student loan fund or scholarship fund, contact Kristin Bjurstrom Krueger, director, Division of Foundation Activities, 330 E Lakeside St, PO Box 1109, Madison, WI 53701; or phone 608-257-6781, or toll-free in Wisconsin 1-800-362-9080.

The CES Foundation takes great pride in its ability to provide students with the much needed aid for their medical educations.■

AMA/NET Simplifies the Task of Keeping Up



With AMA/NET, the on-line medical information network sponsored by the AMA, it's easy to keep up with the latest clinical and biomedical literature, health care business information and medical news. You can access the information you need . . . when you need it . . . with just your computer, a modem and your phone. No computer expertise required!

LITERATURE SEARCHES
- EMPIRES Key Clinical Journals
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- Social and Economic Aspects of Medicine (SEAM)
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MEDICAL NEWS AND PUBLIC INFORMATION
- **Associated Press Medical News Service**
- **Public Information Services** Sources include CDC, the Surgeon General and NLM/NIH.
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- **MEDICOM® Drug Interaction Database** – The only on-line, generic ingredient-based drug interaction database. From Professional Drug Systems, Inc.
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Call 1-800-426-2873

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A Guide to Gifts, Bequests, and Trusts

Life is Short . . .
Art is Long . . .
Experience is Difficult

ONE OF THE first recorded admonitions of Hippocrates to fellow physicians concerning medicine are the Latin words contained in the emblem symbolic of this Foundation. These words as they appear in their literal translation as above are as true today as they were when first spoken.

It is indeed obvious that the need for more and better medicine is becoming more and more paramount as we better understand the human process.

Together with this growth of knowledge must come increased public understanding of it, so that the people it is to benefit will take advantage of its availability.

One fine means of accomplishing this is through the efforts of an educational and scientific foundation specifically formed for these purposes.

Obligations and opportunities for the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin to support projects vitally affecting medicine and the health of the people of the State of Wisconsin are awaiting. This guide to gifts, bequests and trusts is designed to assist you in considering the many ways in which you may support the CES Foundation.

BEQUESTS

Bequests are the giving of property by will. The will is designed to assure that upon death your property is distributed exactly in accord with your wishes. One of the purposes of a will can be to perpetuate your name or that of a friend through an organization such as the CES Foundation.

You can achieve such a purpose to benefit the Foundation with simple wording in your will, such as the following:

> **"I give to the CES Foundation of the State Medical Society of Wisconsin, a nonprofit, nonstock Wisconsin Corporation, the sum of $_____ (or specifically described personal property).**

You may add whatever other details you wish concerning the use you wish the Foundation to make of these funds, or who is to be mentioned.

A *codicil* is an amendment or revision of a previously executed will. Your attorney can draft it with minimal cost should you wish to add a bequest to the CES Foundation to your present will.

GIFTS

These are a popular and relatively simple means of supporting the CES Foundation and its many activities.

Such gifts may be designated as unrestricted or for specific immediate use at the discretion of the Foundation trustees. They also may be restricted or earmarked for specific purposes of interest to the donor. Likewise, these gifts also may be designated for permanent investment with only the income used to support Foundation programs.

Cash gifts. Most gifts received by the Foundation are in the form of cash, personal checks made payable to the CES Foundation. These gifts, as well as others, may be designated in honor of a relative, friend, or associate. Immediately upon receipt, the Foundation will mail a card to the individual indicated as well as acknowledgment to the donor.

Gifts of life insurance. Life insurance offers an easy means to make a substantial gift as well as to provide tax advantages for the donor. A policy can be assigned to the Foundation whether it is paid up, partially paid up, or new. Proceeds from such policies may be exempt from estate taxes and if the assignment is irrevocable, present values and future premium payments may qualify as charitable contributions for income tax purposes. The gift of life insurance is deductible, usually at its cash surrender value, at the time of transfer to the Foundation. Arrangements also may be made to provide life income for a beneficiary by having the proceeds placed in a gift income plan with the proceeds, following the life of the beneficiary, to go to the Foundation.■

Charitable, Educational and Scientific Foundation

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Kristin Bjurstrom Krueger, Madison
Executive Director
Kathleen K Mohelnitzky, Madison
Administrative Assistant

CES Foundation facts

THE CHARITABLE, Educational and Scientific Foundation of the State Medical Society of Wisconsin is a nonprofit, nonstock Wisconsin corporation, which was chartered in June 1955. Its purpose is to "engage in, assist, and contribute to the support of charitable, educational, and scientific activities and projects and to contribute to the support of, and to create and maintain, charitable, educational, and scientific institutions, organizations, and funds of any and every kind."

Management: The Foundation's governing power is vested in a Board of Trustees composed of directors and officers of the State Medical Society of Wisconsin, other medical and nonmedical members elected by the Board of Directors, and one representative elected by each component medical society. Nonmedical members may be elected from time to time by the Board of Directors of the State Medical Society of Wisconsin, but the number of such trustees shall not at any time be less than five (5) or more than ten (10).

The Board of Directors of the Corporate Trustees consists of 15 members including the President, Vice President and Treasurer of CESF, and in addition, 12 members, 7 of whom may be nonmedical trustees, each elected for staggered three-year terms.

Registration: The Foundation is registered with the Secretary of State as a charitable organization for purposes of contributions and fundraising under Sec. 440.41 (2) of the *Wisconsin Stats.*

Legal: The Foundation retains Robert B L Murphy of the firm Murphy & Desmond, SC, 2 E Mifflin St, Madison, Wisconsin 53703, telephone 608/257-7181, for advice on legal and tax matters.

Tax information: Contributions to the CES Foundation are tax-deductible under both state and federal tax laws. The Foundation is a 501 (c) (3) corporation. As in all matters relating to your financial affairs, the valuation, form and tax aspects of gifts to the Foundation should be discussed with your attorney, accountant or other advisor.■

SEVENTH ANNUAL
FORT CRAWFORD

CIVIL WAR
ENCAMPMENT

July 30-31, 1988
Prairie du Chien, Wisconsin

Civil War encampment groups from around the Midwest
will converge upon Fort Crawford, a reconstructed Civil War hospital,
for a weekend of living history. Activities that the whole family
can enjoy are planned throughout the weekend.
Camps will be open for public inspection and will provide
visitors with a first-hand look at Civil War soldiers,
their equipment and activities.

Sponsored by the Okeefenokee Rifles

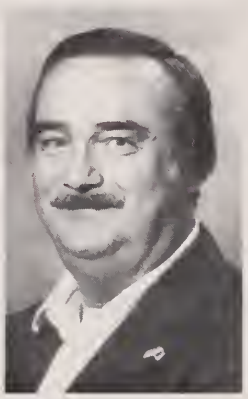
For more information call: 608/257-6781, ext. 183.
Or Write:
Fort Crawford, 717 S. Beaumont Road, Prairie du Chien, WI 53821

OFFICERS AND DIRECTORS: 1988–1989

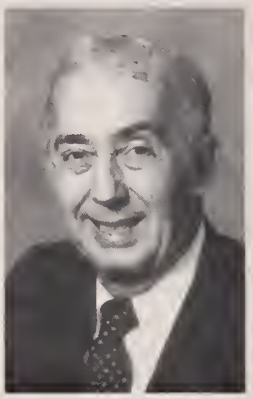
Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin

Robert T Cooney, MD
Portage
President

S B Webster, MD
La Crosse
Vice President



R W Edwards, MD
Richland Center
Treasurer



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"The Beaumont 500"

One of the most unique educational and cultural institutions in the midwest if not the nation, is the Fort Crawford Medical Museum. It is far more than a museum, it is a tribute to all Wisconsin physicians and their role in securing the good health of the people of the State of Wisconsin. It represents a unique concept in the public education for prevention and treatment of injury and disease, the nature of medical care, the importance of the strong physician-patient relationship, and emphasis on obtaining and keeping good health.

The restored Fort Crawford military hospital and its related museum in Prairie du Chien, is a tribute to Dr William Beaumont; it is also a modern expression of his 1830s philosophy of the search for truth and improvement in health. Museum planning began in 1931 when the State Medical Society placed a granite memorial on the site of the Second Fort Crawford Military Hospital where Doctor Beaumont did his famed work. In the mid-1940s the State Medical Society's House of Delegates endorsed the furnishing of the hospital building as a museum. In the 1950s the property was deeded to the CES Foundation and the State Medical Society gave unanimous official approval to completion of the museum complex and later the Stovall Hall of Health.

In late 1981 the **MMP Endowment Fund** was established to aid the museum. Although over 200,000 visitors have passed through the museum's doors, it continues to face financial hardship as well as some physical ailments. This Fund has a goal of raising at least $500,000, the corpus of which cannot be used for any purpose other than to produce income earmarked for operation and maintenance of this National Historic Landmark.

The first 500 physicians or others who contribute $1,000 or more to the Museum Endowment Fund will join a select group known as the "**Beaumont 500.**" Such contributors will receive a specially-designed Beaumont Medallion.

To date, 34 individuals have contributed $1,000 each to the Museum Endowment Fund and several more have pledged support. Through the continued generosity of Wisconsin physicians and their spouses, the Fort Crawford Medical Museum can continue to familiarize our citizens--young and old—with the fascinating people and events that have helped shape Wisconsin medicine.

MEDICAL MUSEUM ENDOWMENT FUND

Name_____

Address_____

City/State/Zip _____

☐ Yes, I (we) would like to be a member of The Beaumont 500. Enclosed is my (our) contribution of $1,000 or more.

☐ Yes, I (we) would like to be a member of The Beaumont 500. Enclosed is my (our) contribution of $10,000 or more.

☐ Yes, I (we) would like to support medical history by contributing to the Medical Museum Endowment Fund. I am enclosing $_____.

STATE MEDICAL SOCIETY OF WISCONSIN

Accreditation Program

for Continuing Medical Education

REPRESENTATIVES OF THE American Medical Association took the initiative to bring about the unification of a body responsible for accreditation of continuing medical education. This effort resulted in the adoption by the AMA House of Delegates at its Interim Meeting in December 1980 of the report of the Board of Trustees recommending the creation of the Accreditation Council for Continuing Medical Education (ACCME) and the bylaws for this new organization (which became operational January 1, 1981) and assumed the responsibility for national accreditation of organizations, institutions, and agencies offering continuing medical education. The state medical associations will retain the responsibility for accreditation of intrastate continuing medical education in accordance with the agreements reached in the creation of ACCME as stated in its bylaws.

The State Medical Society of Wisconsin's accreditation program functions under the authority of the AMA's Accreditation Council for Continuing Medical Education (ACCME). Representatives from state medical societies, national medical specialty societies, AMA Section on Medical Schools and Resident Physician's Section, National Medical Association, American Hospital Association, Association for Hospital Medical Education, Federation of State Medical Boards, and medical specialty boards comprise the ACCME.

The Commission on Continuing Medical Education of the State Medical Society of Wisconsin and its Subcommittee on Accreditation currently review and accredit 59 hospitals, 25 specialty societies, and one county medical society in the State of Wisconsin.

Information is available in printed form from either Bill Wendle, Scientific and Information Services Coordinator, or Sandra Columbus, Administrative Assistant, Continuing Medical Education, State Medical Society of Wisconsin, PO Box 1109, Madison, Wisconsin 53701; or telephone toll-free in Wisconsin 1-800-362-9080 (Madison area: 608/257-6781).

Category 1—CME activities with accredited sponsorship . . . Education activities that are a part of a planned program of continuing medical education and sponsored by an accredited organization . . . (including)

- Grand rounds
- Teaching rounds
- Departmental scientific meetings
- Seminars and Workshops
- Clinical Traineeships
- Mini-residencies
- Scientific sessions of medical specialty societies
- Visiting lecture programs
- Continuing medical education courses
- Audiovisual materials (under specified conditions.)

Category 2—CME activities with non-accredited sponsorship (same activities as in Category 1, offered by a non-accredited medical organization. No formal approval is necessary for an organization to offer Category 2 credit).

Category 3—Medical teaching.

Category 4—Papers, publications, books, presentations, and exhibits.

Category 5—Non-supervised individual . . . activities (includes) self-learning, consultations, patient care review, self-assessment, specialty board preparation.

Category 6—Other meritorious learning experiences.

continued on opposite page

CME Accreditation Program/*continued*

WISCONSIN INSTITUTIONS AND ORGANIZATIONS ACCREDITED *by SMSW and ACCME for continuing medical education programming at January 1, 1988*

Appleton Memorial & St Elizabeth Hospitals, Appleton
Bellin Memorial Hospital, Green Bay
Beloit Memorial Hospital, Beloit
Berlin Memorial Hospital, Berlin
Columbia Hospital, Milwaukee
Community Memorial Hospital, Menomonee Falls
Eagle River Memorial Hospital, Eagle River
Family Hospital, Milwaukee
Ft Atkinson Memorial Hospital, Ft Atkinson
Good Samaritan Medical Center, Milwaukee
Gundersen Medical Foundation Ltd and La Crosse Lutheran Hospital, La Crosse
Hartford Memorial Hospital, Hartford
Howard Young Medical Center, Woodruff
Kenosha Memorial Hospital, Kenosha
Lakeland Hospital, Elkhorn
Langlade County Memorial Hospital, Antigo
Luther Hospital, Eau Claire
Meriter-Madison General Hospital, Madison
Memorial Hospital of Iowa County, Dodgeville
Memorial Hospital of Oconomowoc, Oconomowoc
Mercy Hospital, Janesville
Mercy Medical Center, Oshkosh
Meriter-Methodist Hospital, Madison
Mount Sinai Medical Center, Milwaukee
Osseo Area Municipal Hospital, Osseo
Reedsburg Memorial Hospital, Reedsburg
Riverside Community Hospital, Waupaca
Sacred Heart Hospital, Eau Claire
Sacred Heart/St Mary's Hospitals, Inc, Rhinelander
Sauk Prairie Memorial Hospital, Prairie du Sac
Shawano Community Hospital, Shawano
Sheboygan Memorial & St Nicholas Hospitals, Sheboygan
St Agnes Hospital, Fond du Lac
St Alphonsus Hospital, Port Washington
St Catherine's Hospital, Kenosha
St Clare Hospital, Baraboo
St Clare Hospital, Monroe
St Francis Hospital, Milwaukee
St Francis Medical Center, La Crosse
St Joseph's Hospital & Marshfield Clinic, Marshfield
St Joseph's Hospital, Milwaukee
St Joseph's Community Hospital, West Bend
St Luke's Hospital, Milwaukee
St Marys Hospital Medical Center, Madison
St Mary's Hospital, Milwaukee
St Mary's Hospital, Port Washington
St Michael Hospital, Milwaukee
St Michael's Hospital, Stevens Point
St Vincent Hospital, Green Bay
Stoughton Hospital Association, Stoughton
Theda Clark Memorial Hospital, Neenah
Trinity Memorial Hospital, Cudahy
Veterans Administration Medical Center, Tomah
Watertown Memorial Hospital, Watertown
Waukesha Memorial Hospital, Waukesha
Wausau Medical Center, Wausau
West Allis Memorial Hospital, West Allis
Winnebago Mental Health Institute, Winnebago

* * *

American Cancer Society, Wisconsin Affiliate
American Heart Association, Wisconsin Affiliate
Arthritis Foundation: Wisconsin Chapter
Fox Valley Academy of Medicine
Madison Academy of Internal Medicine
Milwaukee Academy of Medicine
The Milwaukee Academy of Surgery
The Milwaukee Gynecological Society
Milwaukee Ophthalmological Society
Milwaukee Orthopaedic Society
The Racine Academy of Medicine
Wisconsin Academy of Family Physicians
Wisconsin Academy of Ophthalmology
Wisconsin Allergy Society
Wisconsin Association for Perinatal Care
Wisconsin Dermatological Society
Wisconsin Neurological Society
Wisconsin Psychiatric Association
Wisconsin Surgical Society
Wisconsin Urological Society
Wisconsin Society of Obstetrics and Gynecology
Wisconsin Society of Otolaryngology —Head and Neck Surgery
Wisconsin Society of Pathologists
Wisconsin Society of Plastic Surgeons
The Wisconsin Society of Radiation Oncologists

* * *

Marinette-Florence County Medical Society

* * *

ACCME Accredited
Dept CME, Medical College of Wisconsin
Dept CME, UW Center for Health Sciences
Interstate Postgraduate Medical Association
State Medical Society of Wisconsin
Wisconsin Society of Anesthesiologists

Membership facts

Whether you're just starting medical school, maintaining a full-time practice, or retiring, SMS has a membership classification to fit your individual needs. Election to membership by the County Medical Society in which your principal place of practice is located carries with it membership in the State Medical Society of Wisconsin and, if you wish, the American Medical Association. If you qualify for resident membership at the time of your election, your membership dues are greatly reduced. This may also qualify you for reduced dues the first two years of your practice. In addition, two-physician families may be eligible for a $50 discount on total SMS membership dues. Dues for regular membership in 1988 are $480 for SMS, $375 for AMA, and county society dues vary. A more detailed listing of SMS membership classifications and their corresponding dues follows:

State Medical Society of Wisconsin

DESCRIPTION OF MEMBERSHIP CLASSIFICATIONS

Regular: Member in active practice. • ***First year in practice***—physicians elected to SMS membership within six months of completing residency, fellowship, or fulfillment of government obligation enjoy a dues reduction of 50 percent for the first year • ***Second year in practice***—physicians who quality by meeting the above criteria enjoy a 25 percent dues reduction during their second year of practice • ***Two-physician family***—one member (spouse) of a two-physician family is entitled to a dues reduction of $50 or the amount of their State Society dues whichever is less.

Resident: Physician who at January 1 of dues year is in an approved training program as a hospital resident or research fellow who is licensed to practice medicine and surgery in Wisconsin.

Military Service: Members who are serving in the U.S. armed forces or Public Health Service (generally not to exceed five years).

Associate: Member whose dues are waived because of financial hardship due to illness or disability. This classification is temporary and is reviewed on an annual basis

Life: Member who has held membership in a state medical society for 50 years or is a Past President of the State Medical Society of Wisconsin.

Honorary: Member who was named by the Board of Directors in recognition of long and distinguished service to the cause of medicine

Retired: Member who has completely retired from practice (works less than 240 hours per year). All dues are waived unless county society indicates they wish to charge county dues.

Part-time Practice: Physician, regardless of age, who practices 1,000 hours or less during the calendar year but does not qualify for retired membership.

Over Age 70: Member in active practice who is over 70 years of age as of January 1.

Candidate: Member attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure.

Scientific Fellow: The Board of Directors may by invitation and unanimous consent confer upon any person engaged in teaching of or research in one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy the status of Scientific Fellow.

Emeritus: Retired members who have chosen not to renew their license.

1988 DUES AMOUNTS FOR THESE CLASSIFICATIONS

	SMS	AMA	COUNTY
Regular	$480.00	$375.00	Normal County Dues
1st Year in Practice	$240.00	$187.00	Normal County Dues
2nd Year in Practice	$360.00	$281.00	Normal County Dues
Two Physician Family	$430.00	$375.00	Normal County Dues
Part-Time Practice	$240.00	$375.00/-0-	Normal County Dues
Part-Time—Over Age 70	$240.00	$187.00*	Normal County Dues
Resident	$ 48.00	$ 45.00	Varies
Military Service	-0-	$250.00/$45.00	-0-
Associate	-0-	-0-	-0-
Retired	-0-	$375/$75/-0-*	-0-
Retired—Over Age 70	-0-	-0-	-0-
Life	-0-	$375.00/-0-*	-0-
Honorary	-0-	$375.00/-0-*	-0-
Over Age 70	$240.00	$375.00/-0-*	Normal County Dues
Candidate—			
Student	[1]$ 10.00	[2]$ 20.00	-0-
Postgraduate—One	$ 10.00	$ 45.00	Varies
Scientific Fellow	-0-	-0-	-0-
Emeritus	-0-	-0-	-0-

[1]Students' SMS and County Dues for four academic years
[2]Students' AMA Dues for the calendar year 1988

*Physicians in these categories may be eligible for exemption from paying AMA dues under the grandfather clause

AMA dues-exempt members who were granted exemption before 1986 based on previously established criteria with the exception of financial hardship or disability will automatically be dues exempt in 1986 and beyond under the grandfather clause

Under new AMA policy only the following two categories of physicians will qualify for new dues exemption:
(1) Financial hardship and/or disability
(2) 70 years of age or older *and* fully retired

Under age 70 and fully retired AMA dues may be reduced to $75.00

Your membership in organized medicine . . .

. . . will help ensure the continued "safety" of your practice and quality care for all patients. Your voice *will* be heard through participation. Membership in the State Medical Society of Wisconsin also requires membership in the county medical society (AMA membership is optional but encouraged). For Regular, Part-time Practice, or Over Age 70 membership classifications, dues may be paid in one lump sum or in two equal installments: one-half of the total payable by January 1, the other half not later than May 15, 1988 which is the removal date for those members who have not completed payment You are urged to renew your membership.

State Society dues are prorated on a monthly basis for those elected to membership July 1 through September 30. Those elected after September 30 have no dues payable for the balance of the year in which they are elected. AMA dues follow the same pattern except prorating is on a semiannual basis rather than monthly basis.

To begin the membership process, if your practice is or will be located in Wisconsin, or you have any questions, you may contact your local county society or call the Membership and Communications Division of the State Medical Society, if in Wisconsin: 1-800-362-9080 (Madison area number 257-6781).

Wisconsin physicians and Worker's Compensation

An overview—modified from a pamphlet prepared by the Worker's Compensation Division of the Wisconsin Department of Industry, Labor and Human Relations

AT ONE TIME or another, many Wisconsin physicians will become involved with patients who have been injured or become ill because of a work-related incident. Wisconsin physicians play a major role in the successful administration of the Worker's Compensation system. This article is designed to help physicians in their important responsibility.

Worker's Compensation (WC) insurance provides three distinct benefits for patients who have injuries or illnesses related to employment:

1. Coverage for health care expenses;
2. Payments for temporary loss of wages; and
3. Payments for permanent loss of earning capacity.

Determination of work-relatedness

Eligibility for WC benefits is determined by doctors. In general, this is simple—such as acute injuries arising from traumatic incidents at work. For disease processes, the determination can be much more difficult. The connection between a disease and employment is heavily dependent upon assessment of the "degree of exposure" to a particular chemical or physical agent or a biomechanical strain.

Doctors and employers can work together to provide specific information about the work history or the specific job the injured worker was doing when hurt. Open communication improves the decision-making capability of the doctor and provides more credible opinions, particularly when cases are litigated.

The doctors' decisions regarding work-relatedness, diagnosis, and initial treatment are conveyed through the Worker's Compensation Division's WC-16B form, entitled "Practitioner's Report on Accident or Industrial Disease in Lieu of Testimony." Completion of the form may be requested by an insurance carrier, an employe-patient, or an attorney. Upon completion, it should be returned to the party requesting it and will generally eliminate the need for testimony at a WC hearing. Failure to submit the form could result in a subpoena.

It is important for doctors to be independent, scientific, and objective in their evaluation and treatment of patients. Prompt and regular reports will assure prompt and regular payment of benefits to the worker. Such payment reduces anxiety and promotes healing.

A special brochure, "Guide for Wisconsin Doctors Using The WC-16B Form" (WKC-7760) is available to help you. A copy can be obtained from the:

Public Education Office
Worker's Compensation Division
PO Box 7901
Madison, WI 53707
201 E Washington Ave
(608) 266-8480

Temporary disability

Worker's Compensation is primarily a healing and return-to-work program and secondarily a legal system. It is very important for all parties in the WC system (employers, insurance carriers, patients and doctors) to help return the injured or ill worker to the job as soon as possible. Eligibility for temporary disability benefits is determined, and must be managed, by the doctor. Most employers have become aware of the advantages of early return to work, even if in a limited capacity, and a growing body of healthcare research is finding that if the employe is away from the work force for too long, the possibility of returning at all is greatly diminished.

The doctor must determine the appropriate medical restrictions, then allow the employer an opportunity to assign suitable work, if available. If none is available at that time, temporary disability benefits are continued until the employe-patient is able to return to work in some capacity. Again, open communication with the worker and employer allows the doctor to best manage the disability aspect of the injury.

Permanent disability

When an employe-patient's condition has leveled off and the prospect for future improvement is unlikely, the doctor usually declares that a "healing plateau" has been reached. The patient is then evaluated for any residual permanent disability, gener-

Summary of key points

- Physicians play a major role in the WC system. This article is designed to help physicians in their important responsibility.
- Evaluation of permanent partial disability (PPD) can be very confusing for the physician, as well as the patient. This can lead to delays and hardships for the injured worker, the employer, and the insurance industry.
- It is very important that all parties, including physicians, help return the injured worker to a job as soon as possible, within medical restrictions. Improved communications, coupled with timely reassessment of the worker's present restrictions, can help accomplish this.
- Physicians and employers should work together to provide physicians with specific information about the job the injured worker was doing when hurt. This will help the physician in making judgments and provide more credible opinions, particularly when cases are litigated.

ally referred to as a Permanent Partial Disability (PPD) rating. Delays and confusion can lead to hardships for the injured worker, the employer, and the insurance industry.

PPD applies to the lost use of a physical capacity, mental capacity, or particular body part (or parts) after a temporary injury or disease has reached a plateau. Injured workers may be capable of returning to their previous employment or may have to be returned to some other type of employent within their functional abilities. Permanent disability is awarded for the potential, or actual, loss of earning capacity.

The Wisconsin WC law has set up a specific "schedule" for many orthopedic injuries, with a corresponding number of weeks for which benefits are allowed. For "scheduled" PPD ratings, the law requires that the degree of disability or loss of function should be compared to total amputation of the affected or nearest joint. For example, total knee replacement is scheduled to be 40 percent loss compared to amputation at the knee. Once the doctor determines (or looks up) the appropriate disability percentage, the amount of benefit is determined by the schedule.

For nonscheduled disabilities (especially head, back, or internal organ disorders) the doctor must compare the individual's ability to work after the injury to that present before the injury. These PPD ratings are generally compared to the body as a whole rather than to a specific joint or function.

The Administrative Code again provides some rough guidance for selected conditions; *ie,* a successful lumbar laminectomy is automatically considered a 5 percent PPD compared to the whole body.

PPD is reported on the WC Division's WC-16 form. This form is sent to the doctor by the insurance carrier or employer, which then forwards a copy to the WC Division, where it is the only record upon which the amount of compensation for permanent disability is made. All questions asked on the WC-16 form have been carefully formulated by the WC community—none is extraneous. Proper completion of the entire form on the first attempt benefits all parties and expedites the payments to the injured employe as well as the doctor.

If there is no ongoing permanent disability, this should be stated explicitly. Vague statements such as "none anticipated" impair the administrative processing of the claim. If surgery was performed, this should be stated. A number of forms have been received that have omitted information such as lumbar laminectomy, that may warrant a PPD rating even though there is no loss of functional ability.

Another Worker's Compensation Division booklet: "How To Evaluate Permanent Disability," also is available to assist doctors. Ask for WKC-7761 from the WC Division.

Worker's Compensation Division

Wisconsin Department of Industry, Labor and Human Relations

MADISON MAIN OFFICE:

Worker's Compensation Division
Room 161
201 E Washington Avenue
PO Box 7901
Madison, Wisconsin 53707
608/266-1340

MILWAUKEE AREA:

Worker's Compensation Division
3rd Floor
State Office Building
819 N Sixth Street
Milwaukee, Wisconsin 53203
414/227-4382

Other items of interest to physicians

• **Disputed health care costs:** Under a 1986 state law, the Worker's Compensation Division now resolves disputes between WC insurers and health care providers over payment of WC-related bills. If a WC insurer or self-insured employer, after studying treatment costs in a geographical area, declines to pay the full cost billed for treatment, the doctor may appeal the decision to the Division.

• **Releases and requests for information:** Under state law a doctor may report an injury or disability to a WC insurance carrier or employer without a release from the injured party. In some cases, when a carrier requests medical information from a doctor, the carrier will have a signed release from the worker.

•**The employe's right to choose a treating physician, chiropractor, or podiatrist:** The injured worker no longer is required to choose a doctor from a panel; any licensed doctor in Wisconsin can be chosen by the worker. An injured person also has the right to a second choice, if the worker has first notified the insurance carrier or self-insured employer of this decision. Referrals from one doctor to another are not considered to be second choices.■

Attending physician's return-to-work recommendations record

PERIODIC MEETINGS have been conducted between physicians and industry representatives through the State Medical Society's Liaison Committee on Health Care Costs. One of the first subjects raised by employers was the return-to-work issue. Considering the lost productivity and escalating costs from both work-related and nonoccupational disorders, it is not surprising why this was a major focus of management. Physicians have a similar concern, albeit for somewhat different reasons. Clinicians have long recognized the beneficial psychologic and physical effects which accrue to most patients by shortening the convalescent period. Of course, any resumption of activity must be consistent with the patient's temporary or permanent restrictions.

The Liaison Committee on Health Care Costs and the Society's Committee on Environmental and Occupational Health believe physicians have a responsibility to cooperate with industry in facilitating their patients' return to work. Employers are entitled to counsel about medical fitness of individuals in relation to work. On occasion, more specific details of the patient's condition, including the diagnosis itself, also may need to be discussed. Signed authorization release is necessary in the latter circumstance and is advisable in the former as well. Having been provided with the necessary medical information by the physician, the employer can then attempt to identify a job which matches the worker's restrictions.

The return-to-work form, shown on opposite page, should facilitate this process. It was independently developed by several individuals including interested medical and industrial groups. It has subsequently been adopted by several county medical societies and undergone slight modifications in content. All reports on its use thus far have been favorable.

The Society's Committee on Environmental and Occupational Health and the Liaison Committee on Health Care Costs have reviewed and endorsed this form. While recognizing that it is not all-inclusive, it does provide the attending physician with functional guidelines for return-to-work recommendations. A narrative section is available for the physician to explain special limitations such as temperature extremes, contact with skin irritants, and visual and hearing problems. A space for authorization release by the patient is provided and must be signed in circumstances where specific medical information such as the diagnosis is given.

Both Society committees recently unanimously recommended its use by Wisconsin physicians, and the form has been submitted for national consideration through the American Medical Association and the American Occupational Medicine Association. The form is not copyrighted and may be reproduced without restrictions. However, the SMS Services, Inc has printed the form in 3-part sets, and these sets are available to Society members upon request to: Return-to-work Form, SMS Services, Inc, PO Box 1109, Madison, Wisconsin 53701; or phone 257-6781 (Madison area); toll-free in Wisconsin (800) 362-9080.■

Wisconsin Clearinghouse

A state agency for information on alcohol and other mood-altering drugs, primary prevention, mental health, and other health topics.

The Wisconsin Clearinghouse is a state agency for information on alcohol and other mood-altering drugs, primary prevention, mental health, and other health topics.

Housed by the University of Wisconsin-Madison, the Clearinghouse offers many publications which are suitable for patient information as well as for professional reference. Dozens of these are available at no cost to Wisconsin residents, except for shipping and handling, and a separate catalog lists over 30 other publications available for purchase. Some of the items are produced by Clearinghouse staff, while others are provided by the Wisconsin Office on Alcohol and Other Drug Abuse, the National Institute on Drug Abuse, the Addiction Research Foundation and other organizations.

In addition to pamphlets, books, professional manuals, public awareness kits and curricula, the Clearinghouse offers many colorful posters aimed at people of many ages and interests. Also available are video tapes on marijuana, caffeine, and the dangers of chemicals unknown to children. The Clearinghouse staff also evaluates films and publications from other sources. Synopses, ratings, and other information on these resources are available on request.

Wisconsin Clearinghouse office hours are 8:30 am —4:45 pm Monday-Friday, although publications may be ordered by mail or telephone. For more information contact Wisconsin Clearinghouse, Dept MJ, PO Box 1468, Madison, WI 53701 (608/263-2797).■

ATTENDING PHYSICIAN'S RETURN TO WORK RECOMMENDATIONS RECORD

Company Name

Patient's Name (Last) (First) (Middle Initial) | Date of Injury / Illness

TO BE COMPLETED BY ATTENDING PHYSICIAN—PLEASE CHECK

DIAGNOSIS / CONDITION (Brief Explanation)

I saw and treated this patient on _____ (Date) and based on the above description of the patient's current medical problem:

1. ☐ Recommend his / her return to work with no limitations on _____ (Date).
2. ☐ He / She may return to work on _____ (Date) with the following limitations:

CHECK ONLY AS RELATES TO ABOVE CONDITIONS

☐ **Sedentary Work.** Lifting 10 pounds maximum and occasionally lifting and / or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.

☐ **Light Work.** Lifting 20 pounds maximum with frequent lifting and / or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and / or leg controls.

☐ **Light Medium Work.** Lifting 30 pounds maximum with frequent lifting and / or carrying of objects weighing up to 20 pounds.

☐ **Medium Work.** Lifting 50 pounds maximum with frequent lifting and / or carrying of objects weighing up to 25 pounds.

☐ **Light Heavy Work.** Lifting 75 pounds maximum with frequent lifting and / or carrying of objects weighing up to 40 pounds.

☐ **Heavy Work.** Lifting 100 pounds maximum with frequent lifting and / or carrying of objects weighing up to 50 pounds.

1. In an 8 hour work day patient may:
   a. Stand / Walk
      ☐ None ☐ 4-6 Hours
      ☐ 1-4 Hours ☐ 6-8 Hours
   b. Sit
      ☐ 1-3 Hours ☐ 3-5 Hours ☐ 5-8 Hours
   c. Drive
      ☐ 1-3 Hours ☐ 3-5 Hours ☐ 5-8 Hours
2. Patient may use hand(s) for repetitive:
   ☐ Single Grasping ☐ Pushing & Pulling
   ☐ Fine Manipulation
3. Patient may use foot / feet for repetitive movement as in operating foot controls: ☐ Yes ☐ No
4. Patient may:

	Not At All	Occasionally	Frequently
a. Bend	☐	☐	☐
b. Twist	☐	☐	☐
c. Squat	☐	☐	☐
d. Climb	☐	☐	☐
e. Reach	☐	☐	☐

OTHER INSTRUCTIONS AND / OR LIMITATIONS INCLUDING PRESCRIBED MEDICATIONS

3. ☐ These restrictions are in effect until _____ (Date) or until patient is reevaluated on _____ (Date).
4. He / she is totally incapacitated at this time. Patient will be reevaluated on _____ (Date).
5. Referred To: ☐ None ☐ Private physician _____ (Doctor)
   ☐ Return Here _____ (Date & Time) ☐ A Consultant _____ (Doctor, Date & Time)

Physician's Signature | Date

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize my attending physician and / or hospital to release any information or copies thereof acquired in the course of my examination or treatment for the injury identified above to my employer or his representative.

Patient's Signature | Date

Physicians can contest Worker's Compensation charge reductions

The Wisconsin Department of Industry, Labor and Human Relations (DILHR) has established an appeals mechanism through which physicians can contest attempt by insurance carriers to reduce charges for patients covered by Worker's Compensation. The appeal can be initiated by completion of a brief, one-page form listing the physician's name, the patient's name, the carrier's name, the amount billed, and the amount paid.

Several insurance carriers and third-party administrators have recently cited a November 1985 amendment to the Worker's Compensation Law as justification for arbitrarily reducing physician charges. SMS reminds members that it is ***DILHR, and not the carriers,*** that has the authority to determine the reasonableness of charges submitted by physicians for the care of patients covered by Worker's Compensation.

DILHR has acknowledged that merely exceeding a carrier's percentile limits does not necessarily constitute an unreasonable charge. Thus, carrier decisions based solely on percentile reimbursement schemes are being reversed by DILHR in favor of the physician. SMS encourages all physicians to appeal or to contest all carrier actions they deem inappropriate. The staff of the SMS Division of Medical Policy and Practice is available to provide members with technical assistance in the appeals process.

A copy of the appeals form appears on the opposite page; members may wish to photocopy this form or they can obtain one from the Worker's Compensation Division, PO Box 7901, Madison, Wis 53707.■

STATE MEDICAL EXAMINING BOARD

Hospitals and others required to report physician disciplinary actions

IN 1985 AND 1986, the Wisconsin Legislature expanded the existing mandatory reporting laws to include the Department of Health and Social Services, HMOs, PPOs, insurance companies, and limited service health organizations as reporting sources.

Under the original mandatory reporting law, Wisconsin Statutes §50.36 (1981), hospitals are required to notify the Medical Examining Board (MEB) within 30 days peer review investigations that result in the reduction or loss of physician medical staff privileges for 30 days or more, or result in a physician resigning from the hospital staff for 30 days or more. (See *WMJ*, June 1985).

Mandatory reporting to the MEB was expanded by two pieces of legislation, the 1985-87 Budget Act and the special session medical malpractice reform bill (signed into law by Governor Anthony Earl, June 12, 1986). Under the provisions of the Budget Act (1985 Wisconsin Act 29), insurers must now report medical malpractice claims information to the MEB on a monthly basis; the Patients Compensation Fund must report panel filings, proceedings or decisions with the MEB on a quarterly basis. In neither case is there any threshold for claims reporting.

The special session medical malpractice bill expands reporting to the MEB to include the department of justice or district attorney with regard to any prosecution of a person holding a license granted by the MEB; DHSS to report any decertification or suspension from either Medicare or Medicaid program participation if the grounds for the suspension or decertification include fraud or a quality of care issue; HMOs, PPOs, or limited service health organizations with regard to suspensions, disciplinary actions or other actions related to unprofessional conduct or negligence in treatment by physicians. Prior to this legislation, none of these sources of physician review or discipline was required to report negative actions to the MEB.

In addition, the special session bill amends Wis. Stats. §50.36 to require hospitals to report any hospital staff privilege reduction, suspension, or resignation done for any reason that include quality or ability to practice. Suspensions, reductions, or resignations that result from reasons that do not include quality of or ability to practice are reported to the MEB under the conditions outlined in the former language of that statute.■

WISCONSIN WORKER'S COMPENSATION DIVISION

Request for Resolution of Health Service Cost Dispute

Instructions: The health service provider should provide the following information for each dispute. The information should be sent to the Worker's Compensation Division *and* the company which took the action in dispute. The information requested must be provided completely in order for a determination to be made.

1. Date: _____

2. Requested by (Name of Health Service Provider): _____

   Address: _____

   _____ Telephone No. _____

3. **Claimant Information:**

   _____

   Name Social Security No. Date of Injury

4. **Service Information:**

Specific Services Provided:	Date	Amount Charged	Amount Paid

5. **Insurance Carrier or Claims Service Information:**

   (Please provide information requested here on the particular company with which you have the dispute.)

   Company Name: _____

   Address: _____

   _____ Telephone No. _____

   Name of company representative with whom this issue was discussed in an effort at resolution:

   _____

   Date(s) of Discussion(s) _____

   Mail to: Worker's Compensation Division
   P.O. Box 7901
   Madison, WI 53707 Attn: Administrator

STATE MEDICAL EXAMINING BOARD

Hospitals required to report physician's loss of hospital staff privileges

STATE LAW requires hospitals to report to the Medical Examining Board peer investigation information which results in a physician's hospital staff privileges being lost or reduced, or which results in a physician resigning from the hospital.

Chapter 135, Laws of 1981, requires hospitals to notify the Medical Examining Board of any loss or reduction of privileges for 30 days or more, within 30 days after the loss, reduction, or resignation takes effect. The new medical malpractice legislation, 1985 Wisconsin Act 340, requires hospitals to notify the Medical Examining Board of suspensions or reductions of less than 30 days, if the suspension or reduction is related to ability to practice or quality of practice. Temporary suspensions due to incomplete records need not be reported.

Within 30 days after receiving a hospital report, the Medical Examining Board must notify the physician, in writing, of the substance of the report. The physician and the physician's authorized representative may examine the report and may place into the record a statement, of reasonable length, of the physician's view of the correctness or relevance of any information in the report. An action may be instituted in circuit court to amend or expunge any part of the hospital report.

If the Medical Examining Board determines a hospital report is without merit or that the physician has sufficiently improved his conduct or competence, the Board must remove the hospital report from the physician's record.

If no hospital reports are filed against a physician for two consecutive years, the physician may petition the Board to remove any prior reports, unless those reports are related to a finding of unprofessional conduct against the physician.

Hospitals may request information relating to a physician's loss, reduction, or resignation of staff privileges from other hospitals prior to admitting the physician to the medical staff.

The law is intended to prevent the migration of physicians who lose attending privileges at one hospital and to shortly thereafter receive approval for attending privileges at another, unsuspecting hospital. It is also intended to help tighten disciplinary efforts and improve risk management related to medical malpractice.

The system requires the Medical Examining Board to act as a clearinghouse for the accumulation and dispersal of disciplinary actions taken by hospitals against physicians.■

CPT/4–1988

CPT/4–1988 is available for $30.00 (if AMA member, 20% discount) (includes postage and handling) from: AMA Order Dept, OP 341/8, CPT/4–1988, PO Box 10946, Chicago, IL 60610-0946.

NOTICE

Wisconsin hospital emergency rooms and outpatient facilities are aware of the following federal and state laws which prohibit . . .

I. Discrimination against patients

Alcohol abusers, alcoholics and drug abusers who are suffering from medical conditions shall not be discriminated against in admission or treatment, solely because of their alcohol abuse, alcoholism or drug abuse by any private or public general hospital or outpatient facility [as defined in section 1633 (6) of the Public Health Service Act] which receives support in whole or in part by funds appropriated to any federal department or agency. Such regulations shall include procedures for determining if a violation of subsection (a) has occurred, notification of failure to comply with such subsection, and opportunity for a violator to comply with such subsection.

U.S.P.L. 91-616, Part C, Section 321 A & B and subsequent amendments

U.S.P.L. 92-255, Section 407 A & B and subsequent amendments

II. Refusal of admission

"A private or public general hospital may not refuse admission or treatment to a person in need of medical services solely because that person is an 'alcoholic,' 'incapacitated by alcohol,' 'or is an intoxicated person' as defined in subsection (2). This paragraph does not require a hospital to admit or treat the person if the hospital does not ordinarily provide the services required by the person. A private or public general hospital which violates this paragraph shall forfeit no more than $500."

Wis. Stats. 51.45 (15) (c)

PLEASE NOTE: Hospitals not equipped to admit or provide treatment to the person must have a written plan and agreement with the nearest hospital that provides services required by the person.

Any violation should be reported to the Bureau of Alcohol and Other Drug Abuse, 1 West Wilson Street, Room 434, Madison, Wisconsin 53702. Phone 608/266-2717.

LET THESE GUIDES AND REPRINTS HELP YOU

THE FOLLOWING GUIDES, manuals, and reprints have been prepared or obtained at the direction of the Board of Directors and/or commissions and committees of the State Medical Society of Wisconsin to be of direct personal assistance to the physician or his county medical society. Each is available (some without cost, others at nominal cost) upon request to the Communications Division, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

- **Occupational Health Guide**—For medical and nursing personnel. First published by the State Medical Society of Wisconsin in the mid-1960s, respected throughout the United States by nurses and physicians in the commercial and industrial setting. 1-5 copies $45.00 each, or $40.00 each for over 5 copies, including postage. Wisconsin residents must include 5% sales tax. Checks to be made payable to: CES Foundation, PO Box 1109, Madison, WI 53701. PAYMENT MUST ACCOMPANY ORDER.

- **Getting the Most Out of Your Health Care Dollar**—Offers tips on how patients can spend their health care dollar wisely and be a cost conscious patient. The brochure also shows where the Nation's Health Care Dollar is spent and explains what doctors are doing to control costs.

- **Rubella—Red Measles Brochure**—This conveniently sized 2½"x4" sized brochure alerts women to the necessity of being immunized for Rubella before they become pregnant. The brochure also reminds parents to have their children immunized for the red measles. Perfect for patient billing statements or waiting rooms.

- **Interprofessional Code (1977 Revision)**—An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.

- **Communications Guide for Wisconsin Hospitals and Physicians**—Establishes a communications guide for Wisconsin hospitals and physicians to promote cooperation between the allied medical professions and those who report medical news.

- **Retention and inspection of patients' records**—Explains the right of access to physician and hospital records concerning patient care, and includes the revised form, through statute amendment, of an *Interpretation* of Chapter 301, Laws of 1959.

- **To All My Patients, Partners in Good Health**—Explains the rights and responsibilities physicians and patients have in medical care. Available in standard brochure or smaller "statement stuffer" form.

- **UPDATE—A Guide to Medicare Audits, Parts One and Two: The WIPRO Review Process/WPS Medicare Review Process**—Provides information on the WIPRO review process—why a physician gets reviewed, the types of reviews, and how to survive a review.

- **Wisconsin's Peer Review Confidentiality and Immunity Statute**—Published in the June 1985 BLUE BOOK issue of the *Wisconsin Medical Journal,* available in reprint form upon request to *WMJ.*

- **UPDATE—Wisconsin's New Law on Medical Liability**—Details the implications of the 1986 Legislature's first attempt to enact medical liability tort reforms in Wisconsin.

- **Medical Liability—A Physician's Rights and Responsibilities**—Provides information about medical liability insurance and outlines the rights and responsibilities of physicians and medical liability insurance carriers in the resolution of medical liability disputes.

- **UPDATE—REACH: Resource for Education and Awareness of Community Health**—A Program to Improve Physician-Public Communications—Examines the changing nature of the public's image of physicians. Explains SMS policies and programs dealing with the media on current medical issues.

- **If You Have a Complaint About Medical Care**—Medical care is a personal matter between patient and physician. Yet, sometimes misunderstandings arise about what the physician hopes to accomplish and what the patient expects. This brochure, aimed at patients, explains the State Medical Society's grievance and peer review system.

- **School Health Examination**—A guide for physicians and school authorities in establishing a program of school health examinations. (Single copy $2.00 plus 5% sales tax with order.)

- **Make Yours a Smokeless Pregnancy**—Points out the dangers of smoking during pregnancy and its effects on the fetus.

- **Workers' Compensation**—Several brochures and booklets are available to assist physicians handling Workers' Compensation cases. Titles include: How to Evaluate Permanent Disability; Wisconsin Doctors and Workers' Compensation—An Overview; and Using the WC-16B for Workers' Compensation.

- *New Title:* **Wisconsin Impaired Physician Program**—Reviews the philosophy and mechanics of this SMS program.

- **Putting the UCR Fee Puzzle Together**—Explains what "usual, customary and reasonable" means, how misunderstandings concerning it can be avoided and how problems can be resolved when they occur. The small size of the brochure makes it suitable for enclosure in office statements or for placement in patient reception areas.

- **So You've Been Sued . . . Now What?**—A brochure prepared by the SMS Physicians Alliance Commission which answers 12 questions physicians commonly ask about medical malpractice lawsuits.

- **Some Straight 'Dope' on Marijuana**—Explains what marijuana is, who uses it, and points out some of the psychological and physiological hazards associated with its use.

- **Alcohol and Your Unborn Baby . . .**—Warns women of the harmful effects alcohol can have on an unborn child. Available in both English and Spanish versions. ■

Summary of State Medical Society policy

Each year the State Medical Society of Wisconsin takes positions on literally hundreds of issues. In an effort to identify major topics on which the Society has established formal policy, either through its House of Delegates or Board of Directors, the following list is provided. More detailed information and complete explanations of SMS policies are available on any of these topics by contacting the Division of Medical Policy and Practice at SMS Headquarters in Madison.

- Aging
  - Physician Extenders (B-8/87)
- AIDS (B-1/88; B-4/88; H-4/88)
  - Education
  - Provision of Care
  - Funding
  - Testing
  - Confidentiality
  - Public Health Measures
  - HIV Antibody Testing and Disclosure (B-10/87; B-8/87)
- Alcoholism (B-8/87)
- Athletic Training Education (H-4/88)
- Auxiliary
  - illegal drugs (B-4/88)
- Birth and Developmental Outcome Monitoring Program (B-10/87)
- Collective Negotiations (B-8/87)
- Confidentiality of Medical Information (H-4/88)
- Continuing Medical Education (B-1/88)
- Contract Negotiations (H-4/88)
- Corporal Punishment in Schools (B-6/87)
- Critical Care Categorization (H-4/88)
- Dental Hygienists Supervision (B-6/87)
- Diabetes Equipment Tax Exemption (B-6/87)
- Diabetes Mandated Insurance Coverage (B-6/87)
- Disabled Parking Privileges (H-4/88)
- Drinking Age of 21 years (B-8/87)
- Drug Testing Laboratory Standards (B-6/87)
- Drug Testing in the Workplace (B-1/88)
- Duty to Warn Principals (B-1/88)
- Emergency Care Education (H-4/88)
- Fetal Monitor Tracings and Destruction of Medical Records (B-6/87)
- Hazardous Air Emissions (H-4/88)
- Health Insurance Risk-sharing Plan Revisions (B-6/87)
- Health Policy Agenda for the American People (B-1/88)
- Hospice Licensure (B-10/87)
- Hospital Rate Setting Commission (B-6/87)
- Immunization Funding (H-4/88)
- Injury Epidemiology (B-4/88)
- IPA Financial Reporting (B-1/88)
- Living Will Modifications (B-6/87)
- Mandated Insurance Coverage (H-4/88)
- Mediation and Peer Review (B-6/87)
- Medicaid
  - Copayments
  - Coverage for Gastric Bypass Surgery (B-6/87)
  - Coverage for Psychiatric/AODA Services (B-4/88)
  - Coverage for Physical Therapy (B-4/88)
- Medical Liability
  - Documentation Charges (H-4/88)
  - Frivolous Suits (H-4/88)
  - Limits on non-economic damages (B-4/88, H-4/88)
  - Mandated Liability Coverage (H-4/88)
  - Medical Liability Education (H-4/88)
  - Patients Compensation Panels (B-1/88)
  - Physician Support Groups (H-4/88)
  - Risk Management/Loss Prevention (B-6/87, H-4/88)
  - Tail coverage (H-4/88)
- Medical Sales Tax (B-8/87)
- Medicare
  - MAAC (H-4/88)
  - Second Opinion Program (B-10/87; B-8/87)
  - Reimbursement Inequities (H-4/88)
  - Rural Hospital DRG Inequities (B-10/87)
- Maternal and Child Health
  - Baby Doe (B-8/87)
- MEDPACT—Safe Transportation (B-8/87)
- Motorcycle Helmets (B-6/87)
- Non smokers: Premium Discounts in the State Life Insurance Plan (B-6/87)
- Nursing (B-4/88)
- Occupational Therapists Licensure (B-6/87)
- Optometric Therapeutic Drugs (B-4/88)
- PartnerCare (B-4/88)
- Pharmacy Scope of Practice (B-6/87)
- Physician-Patient Relationship (H-4/88)
- Pop-Top Cans (B-8/87)
- Pregnancy Counseling Services and Restrictions (B-8/87)
- Respiratory Care Practitioner Regulations (B-8/87)
- Rural Health (B-1/88)
  - Physician Manpower
  - Payment Differentials
  - Health Care Delivery as a Rural Development Strategy
  - Rural Physician Survey
- Sales Tax Expansion Proposal (B-8/87)
- School Linked Health Clinics (B-6/87)
- Seat Belts in School Buses (B-6/87)
- Service Corporation Directors (B-6/87)
- 65 mph Speed Limit (B-6/87)
- Smoke Free Environment (H-4/88)
- Specialty Determination (H-4/88)
- Tax Exemption for Health Cooperatives (B-6/87)
- Uninsured and Health Insurance (B-6/87)■

Crime victim compensation

The Crime Victim Compensation Program in Wisconsin was created in 1975. It is intended to alleviate some of the direct financial burdens faced by the innocent victims of most personal injury crimes committed in the state.

Administered by the Office of Crime Victim Services in the Wisconsin Department of Justice, the crime victim compensation (CVC) program has an annual budget of approximately $1.3 million for benefit programs. Since nearly half of this amount goes to cover medical bills, it is useful for physicians and other health care providers to be familiar with the program.

Program eligibility

Generally, persons eligible for coverage include the innocent victims of crime who suffer physical injury or death (including their surviving dependents and legal representatives), as well as persons injured or killed while aiding a victim or police officer ("Good Samaritan"). In addition, family or household members who suffer a reaction from the death of a victim may also qualify for benefits.

Nearly all personal injury crimes are covered by the program. These include, for example, homicide, manslaughter, battery, assault, sexual assault and abuse of children. In addition, certain victims of drunk driving accidents may also be covered.

The program does not require that an offender be apprehended or prosecuted in order for a victim to obtain benefits.

Persons who themselves committed a crime or whose conduct substantially contributed to the infliction of the injury or death are not eligible for program benefits. Victims must have reported the crime to a law enforcement agency within five days of the incident and must cooperate with appropriate law enforcement agencies in the investigation and prosecution of the case to be eligible for benefits.

As a general rule, victims having a family or household relationship with the offender are not eligible for benefits. The program may, however, waive this restriction in a particular case in which "the interest of justice so requires." This exception is most often used in cases where the victim is a child and occasionally in spouse abuse situations.

Benefits

The maximum award for any one injury or death is $40,000. Expenses eligible for reimbursement are those direct out-of-pocket costs incurred as a direct result of the crime.

Available benefits include payments for medical treatment, which includes medical, hospital, surgical, dental, optometric, and podiatric care. Also covered are payments for medical supplies, such as prescription drugs, crutches, and artificial limbs and appliances (and training in the use of artificial limbs and appliances).

Mental health counseling costs are covered if the service is provided by a licensed psychiatrist or a licensed psychologist. In addition, counseling provided under the supervision of a licensed psychiatrist or psychologist by either a psychotherapist certified under the Wisconsin Medical Assistance Program or by a crisis counselor employed by a recognized crisis counseling agency may also be eligible for coverage.

The program does not pay for pain and suffering or for most types of property losses or damage, although essential personal items, such as glasses and dentures damaged as a direct result of a crime, may qualify for reimbursement.

The second largest category of payments is for lost wages and loss of support to the dependents of a deceased victim. Other eligible expenses include: the reasonable replacement cost of clothing or bedding held as evidence by law enforcement or a crime laboratory (up to $300), reasonable replacement value of other property held as evidence and made unusable by crime lab testing (up to $200), crime scene clean-up and security (up to $1,000), and homemaker services.

In addition, up to $2,000 may be paid for reasonable funeral expenses. This may be in addition to the $40,000 maximum allowable for the other expenses.

As the "payer of last resort," the crime victim compensation program deducts expenses paid by collateral sources, such as private insurance policies or workers' compensation.

Claims processing

The responsibility for filing and pursuing a claim rests with the victim of the crime. To process an application, the program must verify the submitted information and thus requires supporting documentation, including a Physician's Certification. This form describes the victim's injury and the treatment given and can be used in lieu of the physician's testimony if the case goes to hearing.

For further information on the program, please contact Crime Victim Compensation, PO Box 7951, Madison, WI 53707-7951, or call 608-266-6470 (Madison) or 414-227-3987 (Milwaukee).■

THE FOLLOWING FINANCIAL STATEMENTS of the State Medical Society of Wisconsin are part of the Treasurer's Report to the House of Delegates. The Annual Certified Audit, prepared by Bailey and Stolzman, SC, certified public accountants, is on file at Society headquarters. Members wishing to review the Audit may do so upon inquiry to the Secretary-General Manager.

STATE MEDICAL SOCIETY OF WISCONSIN
Madison, Wisconsin

General Fund
BALANCE SHEET
December 31, 1987

ASSETS

Current Assets		
Cash		$ 318,713.85
Accounts Receivable—General		36,247.43
Due from SMS Services, Inc.		73,796.73
Due from SMS Pension Plan and Trust Agreement		2,986.22
Due from Charitable, Educational, and Scientific Foundation, Inc.		6,874.75
Due from Other Organizations for Accrued Payroll and Vacation Pay		38,678.98
Investments (at Fair Market Value):		
Money Market Funds	$ 84,798.00	
Repurchase Agreements	500,000.00	
Commercial Paper	700,000.00	
Certificates of Deposit	300,000.00	
U.S. Government Securities	851,369.79	
Commercial Bonds	240,047.50	
Common Stock	280,087.50	2,956,302.79
Accrued Investment Income Receivable		30,893.20
Prepaid Expenses		33,478.20
Supplies Inventory (At Cost)		15,447.20
Total Current Assets		$3,513,004.25
Fixed Assets		
Real Estate—Office Building	$1,307,455.71	
Real Estate—Storage Building	129,978.96	
Other Real Estate	91,792.59	
Building Equipment	116,313.91	
Furniture and Equipment	329,396.77	
Data Processing Hardware and Software	99,049.93	
Subtotal	$2,073,987.87	
Less: Accumulated Depreciation	1,230,061.97	
Net Book Value	$ 843,925.90	
Less: Leasehold Improvements Paid by Other Organizations	35,156.25	
Net Fixed Assets		808,769.65
Other Assets		
Prepaid Pension Costs	248,285.90	
Long Term Investment in Common Stock—(See Note 1 of Schedule A-1)	435,745.76	
Cash Value of Life Insurance Contracts	6,575.55	
Total Other Assets		690,607.21
TOTAL ASSETS		$5,012,381.11

LIABILITIES

Current Liabilities		
Accounts Payable		$ 69,566.75
1987 Dues Payable to American Medical Association, County Medical Societies, and Other Organizations		6,879.26
Accrued Pension Contributions Payable		100,210.90
Accrued Payroll Taxes and Other Payroll Deductions		489.53
Accrued Property Taxes Payable		66,627.36
Accrued Sales Tax Payable		469.17
Accrued Income Tax		16,925.00
Accrued Payroll and Vacation Pay		121,497.79
Accrued Health Incentive Plan		36,057.38
Other Accrued Expenses		1,060.02
Deferred Income:		
Prepaid 1987 Membership Dues	$2,159,114.70	
Prepaid 1987 Annual Meeting Income	10,375.00	
Prepaid Rental Income	3,709.00	2,173,198.70
Other Current Liabilities		675.00
Total Current Liabilities		$2,593,656.86

continued next column

MEMBERSHIP EQUITY

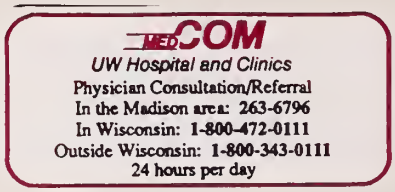
Balance, January 1, 1987	$2,122,974.24
State Medical Society Excess Income Over Expense for the Year Ended December 31, 1987	337,261.39
Net Increase in Value of Investment in SMS Services, Inc. Net Income (loss) $26,511.38 less dividends $15,000.00	(41,511.38)
Balance December 31, 1987	2,418,724.25
TOTAL LIABILITIES AND MEMBERSHIP EQUITY	$5,012,381.11

STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1987

INCOME	
Membership Dues	$2,251,378.96
Income from Invested Funds (1)	133,078.67
Annual Meeting Income	69,055.00
AMA Collection Fees	18,421.12
Wisconsin Medical Journal Advertising, Subscriptions and Reprint Income	97,784.46
Mailing Labels	15,081.80
Equipment and Building Rental	129,158.83
Contract Services Furnished to Other Organizations	12,642.33
Duplicator, Cafeteria and Telephone Costs Recovered From Other Organizations	44,131.05
Other Income	25,968.64
TOTAL INCOME	$2,791,700.86
EXPENSE	
Payroll	$1,099,314.08
Payroll Related Costs	11,321.48
Travel Expense & President's Honorarium	198,431.23
Telephone Expense	75,037.35
Conference Expense	125,255.41
Postage	74,330.06
Outside Services	74,758.56
Printing and Supplies	239,313.59
General Insurance	32,661.60
Association Dues	8,486.90
Resource Materials	7,103.63
Grants and Appropriations	95,371.60
Rent	2,436.00
Property Taxes	66,627.36
Repairs and Maintenance	36,601.56
Mail Service	41,308.69
Depreciation	114,277.07
Speakers Expense	9,412.60
Legal Counsel	5,107.50
Certified Public Accountant Services	35,421.80
Miscellaneous Expense	18,111.47
Provision for Bad Debts	2,040.00
Utilities	52,525.74
Building Supplies	16,688.42
Income Tax Expense	(refund 11,075.00)
Strategic Planning Direct Cost	15,777.09
Lease Buyout Expense (PIC-WISC)	7,793.68
TOTAL OPERATING EXPENSE	$2,454,439.47
EXCESS INCOME OVER EXPENSE	$ 337,261.39

NOTE:
(1) Income from Invested Funds includes a $15,000.00 dividend received by State Medical Society from SMS Services, Inc. during 1987.

The only number you need to reach a specialist at UW Hospital and Clinics



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UW Hospital and Clinics

600 Highland Avenue
Madison, WI 53792

ARMY RESERVE MEDICAL PROFILE NO.7

Soldier being examined for effects of high-altitude cerebral edema.

ALLAN J. HAMILTON, M.D.

Neurosurgical Resident and Research Fellow, Massachusetts General Hospital, Boston, Massachusetts. Captain, U.S. Army Reserve.

EDUCATION Ithaca College, B.A. (Magna Cum Laude); Hamilton College (Pre-med); Harvard Medical School.

RESIDENCY General Surgical Internship. Neurosurgical Residency, Massachusetts General Hospital.

CONTINUING EDUCATION Neurology and Neurosurgery Research Fellowship Training, National Institutes of Health.

OUTSTANDING ACHIEVEMENTS Olsen Memorial Fellowship, National Masonic Medical Research Foundation; Albert Schweitzer Fellowship, International Albert Schweitzer Foundation; Harvard Medical School Cabot Prize for Best Senior Thesis; recently published article, "Who Shall Live and Who Shall Die" in Newsweek Magazine.

"The work I'm doing in the Army Reserve fits perfectly with my academic research interests in civilian life. The Army is very concerned with the effects of high-altitude cerebral edema, which is a mirror model of cerebral hypoxia, something I deal with every day in our neurosurgical intensive care unit. I couldn't ask for a smoother transition. And that's true for a lot of Reserve physicians. All we really do is change our clothes, not our mindset.

"Some of the projects the Army is undertaking are on the cutting edge of research. For example, I'm currently involved in developing for the Army a prototype of a non-invasive intracranial pressure-monitoring device that we hope will allow us to measure pressure changes as the brain swells—without drilling holes in the skull. If we can get our design to work, such a device could revolutionize high-altitude medicine as well as civilian neurosurgical care.

"The quality of medicine and the caliber of people I've been associated with in the Army Reserve are, without question, equal to civilian hospitals. In fact, I'm giving serious consideration to applying for an active duty academic position in Army Medicine when my residency ends at Massachusetts General."

Find out more about the medical opportunities in the Army Reserve. Call toll free 1-800-USA-ARMY.

ARMY RESERVE MEDICINE.
BE ALL YOU CAN BE.

A NEW H_2 Antagonist

AXID® 300mg

nizatidine

Effective once-nightly
duodenal ulcer therapy available in a

Unique Convenience Pak

for better patient compliance

AXID®
nizatidine capsules

Brief Summary. Consult the package insert for prescribing information.

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients, at a reduced dosage of 150 mg h.s. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

Drug Interactions—No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported, it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGDT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGDT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Overdosage: There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LD_{50} values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

PV 2091 AMP [041288]

Axid® (nizatidine, Lilly)

Eli Lilly and Company
Indianapolis, Indiana
46285

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Official Publication of the Medical Society of Wisconsin

WISCONSIN MEDICAL JOURNAL

Managing Editor Mary Angell (l) receives the SMS Meritorious Service Award from Secretary-General Manager Tom Adams (r) at the 1988 Annual Meeting.

Mary Angell retires . . . After 30 years with the SMS, the managing editor of the *Wisconsin Medical Journal* brings her illustrious career to an end (see page 191).

Medicare reimbursement . . . A Wisconsin physician pays heavily for billing mistakes, and Secretary-General Manager Adams considers the implications in his report to the membership (see page 174).

Making the law . . . President J D Kabler, MD, evaluates the Society's progress in the 1987–1988 legislative session and puts forth a call to action (see page 172).

PRESIDENT'S PAGE

Standing up and speaking out

MEMBERS OF THE State Medical Society regard effective representation before agencies of our state government as a crucial function of their Society. Another legislative session has adjourned and it is time to assess whether the Society is fulfilling its function as a representative for its nearly 7,000 members.

More than 2,000 bills and resolutions were considered by the 1987–1988 Legislature, from among which the Society's Physician Alliance Commission, chaired by Dr Robert Purtell, Jr, of Milwaukee, selected 53 as especially significant or germane to the health interests of our patients and, therefore, to the Society and its members of the commission voted to support 39 (80%) of the bills and oppose 14 (20%).

The process of persuading the members of the legislature that our views are valid is arduous—requiring research, long hours, many meetings, much scheduling, coordinating physician testimony at hearings and urging members to call or correspond with their senators and representatives. Opposing arguments must be refuted, legislators unfamiliar with the issues must be informed, and other interested groups (medical specialty societies, allied health professions, other professions and organizations) must be solicited for their support. During the progress of bills through the legislative process of hearings, committee sessions and floor debate, these bills attract amendments which must, in turn, be analyzed and discussed by the commission which forms policy and instructs the Society's Division of Public Affairs, which has a pivotal role in transmitting our views to the legislature.

After all this effort, time and talent were expended, how did we do? Did the Society successfully represent its members to the legislature? No one expects that every position adopted by the Society will prevail in any single session of the legislature, and everyone recognizes that some bills are more important than others. One can, however, devise a crude box score indicative of the fate of the 53 bills upon which the Society took a stand.

Of the 53 health related bills upon which SMS took a position (for or against), the legislature agreed with SMS on 33 (62%) of the bills. Of the bills SMS supported, 23 (59%) became law. Of the bills SMS opposed, 10 (71%) did not become law. One bill of special interest to all Wisconsin physicians, which was supported by SMS, revised the formula used to calculate Patients Compensation Fund premiums. Passage of this law limited the current premium increase to 10% rather than allowing it to rise 30% as initially proposed. The savings to physicians from this law nearly equals a year's dues for SMS members. On the other hand, a tort reform bill supported by SMS died in a Senate committee and will remain an issue when the legislature reconvenes in January 1989. Another issue certain to return, and which the Society will again support, is health insurance for the uninsured and underinsured. Equitable reimbursement of health care for patients will be a major consideration.

Is this a good record? Yes, in the judgment of knowledgeable observers. Our Society *has* been influential in representing the interests of the public and physicians to the legislature. Is this record good enough? No, there is obviously room for improvement, and important problems remain to be resolved. What can be done to improve the record and enhance the Society's influence? The single most powerful improvement would be greater personal involvement (calls, letters, conversations) on the part of physicians with their own legislators, to develop over time a relationship based on mutual trust. Of course, this does not mean a physician and his or her legislators will always agree, but it does mean physicians will always be heard.

Law making is a tedious, uncertain, never finished, sometimes exasperating and always stimulating endeavor. Bismarck said it first: "Those who love sausage and respect the law, should never watch either one being made."■

The ultimate in appreciation of medical history

"*The Beaumont 500*"

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Medicare reimbursement

Elsewhere in this issue of the *Wisconsin Medical Journal,* you will see a most unusual advertisement. The copy appearing in the ad states, "I paid Medicare for my mistake. A Wisconsin physician who learned his lesson. My mistake was not insuring the accuracy of the Medicare Reimbursement Claims that I was submitting. I left the task of preparing the claim forms to my clerical staff and signed the forms they prepared. Even though I did not intend to take advantage of the Medicare Program, I was held accountable for the improper claims I signed. I have refunded the amount that I was overpaid and paid an additional $65,000.00 in penalties. Don't make the same mistake I did."

My first reaction to this ad was indignation: The underlying assumption that Wisconsin physicians need such a reminder is not only absurd, it is insulting. Most physicians correctly and conscientiously file their Medicare charges, and where problems have arisen it has been primarily due to the government's own morass of rules—an ever-deepening quagmire that has changed every year for the last five years.

My second reaction, however, was this: If there was ever any question in the minds of Wisconsin physicians about whether the federal government takes seriously its role in policing reimbursement under the Medicare program, this advertisement should erase all doubt. Inappropriate billing practices, whether intentional or accidental, can have severe consequences. The limits of punishment which may be meted out to physicians by the federal government for inappropriate Medicare billing are substantial. The advertisement I am discussing was part of a settlement agreement between a Wisconsin physician and the US Attorney's Office in satisfaction of a legal action for inappropriate billings to the Medicare program and is being published by the physician to educate his Wisconsin colleagues about the seriousness of the issue.

The purpose of this Secretary's Report is to reemphasize to our members and their staffs the absolute imperative for totally accurate billing systems, whether working with the Medicare and Medicaid programs, third-party payors, or other reimbursement systems. Physicians are ultimately responsible for the acts of their employees, and that includes the actions of the billing and accounting staffs. Be aware of what's going on in your offices. What you do not know can hurt you—severely.

During 1989 and 1990 there will undoubtedly be significant changes in Medicare reimbursement policy for physicians (see Secretary's Report in the April 1988 issue of *WMJ*). The SMS and AMA are working diligently to see that the outcome of those decisions is not only favorable to the profession but brings stability, instead of the current chaotic and nonsensical reimbursement system.

Until these changes occur, however, the State Medical Society of Wisconsin has an active, ongoing program to provide first-rate information and education to you and your staffs to help you cope with the current system. Beginning last fall, the SMS has been sponsoring Medicare seminars across Wisconsin. These one-day seminars—which are continuing through the fall of 1988—are prepared and presented by SMS and WPS Medicare staff and review the entire Medicare claims process. Physicians' employees are instructed in proper preparation of claim forms, correct CPT coding, common claim form errors, MAACS, and the most recent changes in Medicare law. These programs are offered at an extremely low registration fee throughout the state so that they are readily accessible to physicians and their staffs.

THOMAS L ADAMS
Secretary-General Manager

I am pleased to report that more than 1,200 individuals have attended these training sessions to date, and that evaluations of the seminars by the attendees have been overwhelmingly positive. WPS Medicare reports that the instance of coding errors has been significantly reduced statewide since the inception of the seminars.

Because of the success and popularity of the Medicare education seminars, they will be repeated again this fall. If your billing staff has not already attended one of the Society's training sessions, please enroll them in one of the upcoming programs. See page 187 for a registration blank and additional information.

To those members who ask, "What has my medical society done for me lately?" I can offer these training seminars as a tangible example of the service and expertise provided by your professional association here in Wisconsin. I also encourage you once again to contemplate the fate of the physician who placed the ad and the horrendous costs attendant to inappropriate billing practices. It's been said that knowledge is power; let your professional association empower you.■

Change is in the air

On May 20, the *Wisconsin Medical Journal* entered a new era. On that day, the Editorial Board met for the first time since the retirements of Medical Editor Victor Falk, MD, (after 27 years on the board) and Managing Editor Mary Angell (after 30 years at the SMS). It was only the second meeting of the board since the retirement of Secretary-General Manager Earl Thayer who had, during his 30 years with the SMS, served first as managing editor and later as publisher of the *Journal.* A time of change had come.

While the contributions of those who have nurtured the *Journal* since its birth in 1903 cannot be over-estimated, new leadership and a new staff will bring a new vitality to the publication and guide it through its next stage of development. This is as it should be.

At the May meeting, the Editorial Board and *Journal* staff charted the initial steps of their new course, and this new "Voice of the SMS" section represents one of those steps. The new policy on publishing opinions in the *Journal,* adopted by the Editorial Board, follows.

There are five forums of opinion in the *Wisconsin Medical Journal:*

The President's Page

Written by the president of the SMS on a monthly basis.

The Secretary's Report

Written by the SMS secretary-general manager on a periodic basis.

Voice of the SMS

This is the official voice of the *Wisconsin Medical Journal.* Opinions here must conform to SMS policies and resolutions, are written only by SMS elected officers, and are published unsigned.

Editorials

The editorial section is the forum for the SMS leadership to express their personal opinions. Editorials may be written only by members of the Editorial Board, editorial associates, SMS elected officers, and members of the SMS Board of Directors. All editorials must be signed by the authors and, although subject to an editor's note, they may be denied publication only for legal concerns.

Letters to the Editor

The letters section is intended to be as open a forum as possible for all members of the SMS. Letters to the editor must be signed by the authors, are limited to 500 words or less, and are subject to an editor's note. Publication may be denied for concerns of either the Editorial Board or SMS legal counsel.■

Join the "Beaumont 500 Club"

The Fort Crawford Medical Museum at Prairie du Chien—a national historic landmark—is in need of special financial support to assure its preservation and to aid its restoration and expansion as a medical and public health museum. Originally restored with WPA funds in the mid-1930s, the museum is in need of major repairs and renovation as well as completion of a Medical Hall of Fame, special displays featuring medical memorabilia from Wisconsin medical families, and the expansion of audio-visual presentations in the Dessloch Theater and Stovall Hall of Health.

Physician and other support is solicited to establish the Medical Museum Endowment Fund, a permanent fund of at least $500,000, the income from which is earmarked for the operation and maintenance of the museum. Contributions of any amount are encouraged.

The first 500 physicians or others who contribute $1,000 or more to the Museum Endowment Fund will join a select group known as "The Beaumont 500." All contributors will receive a newsletter, but Beaumont 500 contributors will receive a specially designed Beaumont Medallion and an invitation to an annual medical history dinner. Those who contribute $10,000 or more will receive a first edition copy of Dr William Beaumont's famous book: *Experiments and Observations on the Gastric Juice and the Physiology of Digestion* published in 1833.

All gifts are tax-deductible. For further information contact CES Foundation, PO Box 1109, Madison 53701.■

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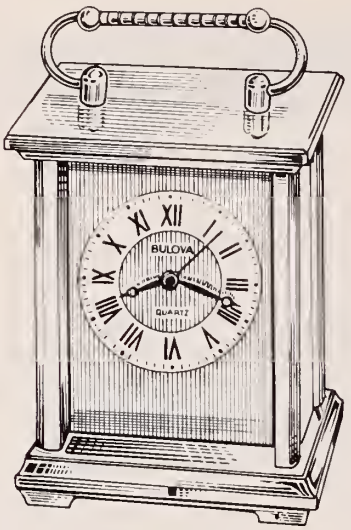

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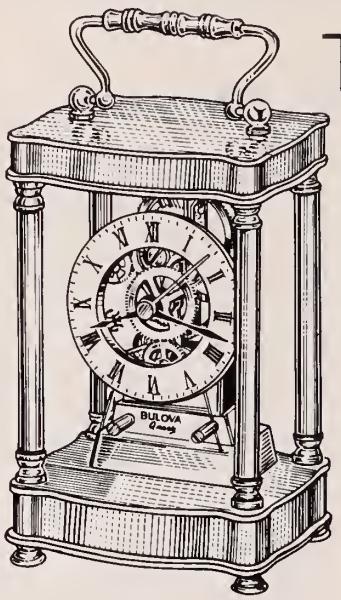

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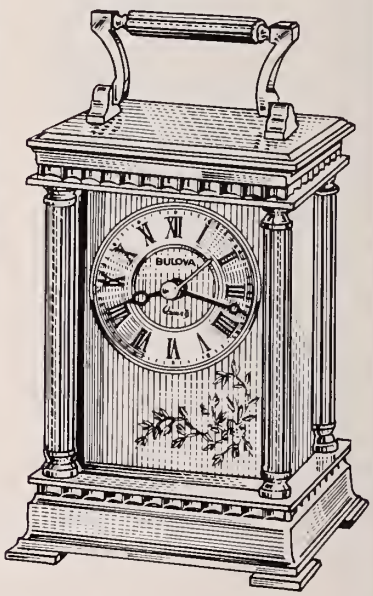

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Burn 'em open

At a recent surgical meeting, I visited with a retired prominent surgeon. Just the day before, he had assisted a resident doing a cholecystectomy. He was aghast at the "burn 'em open, staple 'em shut" routine. He was even more distressed by the use of a coagulating current within the abdomen. He wondered if the training of this young man included any use of a cold scalpel or closure using suture material.

Certainly some of these newer techniques cut down on operating room time and anesthesia time, both considerations in cost containment. There may be times and situations, however, where all of the sophisticated refinements might not be available. For example, in the event of an extensive emergency or for anyone working overseas, the surgeon must be more flexible. As it is expressed in Southeast Asia, "be like the bamboo, bend with the wind." In other words, be flexible.

Anyway, it is essential that the personnel in training be acquainted with some of the techniques which might be considered a bit archaic.

—*Victor S. Falk, MD*
Edgerton

Wheels that never squeak

Periaudacuity (per-i-au-da-cu-i-ty): *The medical phenomenon wherein the ability of legislators to hear their constituents becomes more acute, occurring in a periodic fashion corresponding to election times.*

Periaudacity (per-i-au-da-ci-ty): *A periodic increase in the number and degree of audacious requests/demands/promises made between political candidates and the voting public, the fluctuation of which also corresponds to election times.*

This being an election year, the incidence and virulence of the above mentioned conditions will certainly increase. Social Security, health care reform, AIDS, and other causes will demand—and get—much attention, some of it deserved. Physicians will be giving a lot of attention to dealing with the incursions made by legislators and the marketplace into the practice of medicine. If nothing else, the periodicity of our political system ensures that most special-interest groups will develop—and use—their political savvy ("clout" in Chicago*) to exert their influence on candidates up for election, and thereby achieve their goals.

There are other groups—important groups—in our society who cannot speak for themselves and therefore cannot protect their own interests. Of these, the most important group by far is children. Children lack the voice, the organization, and the clout of groups like AIDS patients, the NRA, or the AARP. There is no question, however, that the importance of children to a society eclipses that of *any other group,* because children represent the future—all other groups represent mere facets of the *status quo.*

And how does society regard its responsibility toward children, its most precious resource? Well, society has always found novel ways to push its children to the limit and beyond. Obviously, war, epidemic, and famine take their toll. But consider also the stresses in a society at peace—abuse, drugs, "hurrying," child labor, pornography, the day-care crisis, moral and ethical vacillation—you name it, it's been done *and is being done* to our children.

The sad thing is, history demonstrates that most of a society's abuse of its children does not occur intentionally. It's not that a society does not feel that its children are important. It is usually just that most people in the society feel that another cause or project is more important. One wonders what the world might be like if all major decisions hinged on the question, "How will it affect our children?" I find myself wondering how the world might be different today if more people had asked that question in generations past.

Society tends to regard its children as wheels that never squeak—that is, regardless of circumstances children rarely complain, and so it is assumed that everything being done with them, for them, or to them is basically OK. This is a false assumption, however. Children have an amazing tolerance in the face of adversity. Indeed, it may be argued that society's ability to recover from war, famine, or other disasters is as much due to

the resilience of its children as to any other factor.

Since our society is not currently at war or facing famine or other national cataclysm, it would seem reasonable to assume that we are therefore not demanding great resilience on the part of its children. This is not the case, however. The fact that so many of our country's problems center primarily on children—day care, drugs, abuse—indicates that our society has not been asking the question, "How will it affect our children?" often enough. As medical care becomes more politically oriented, we as physicians must increasingly go to the public and "bring distress to the comfortable," even as we continue to bring comfort to the distressed, to change public policy toward our children. The children whose plight we ignore today will be running the world before long. Keep that in mind as you write your legislators to let them know that you advocate for children—and you expect them to do the same.

—*Jeffrey H. Lamont, MD*
Wausau

*The opinion of etymologic Neanderthals in Cleveland notwithstanding, this word in this context originated in Chicago.■

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LETTERS

Streptokinase therapy: the author responds

TO THE EDITOR:

I wish to thank you and your editorial staff for publishing our paper "Streptokinase Therapy for Acute Myocardial Infarction" in the May 1988 issue of the *Wisconsin Medical Journal*. I think that it is appropriate, however, to clarify a few items and to respond to the comments of your reviewers, Dr Reinhart and Dr Green.

First, this is a retrospective analysis of a large consecutive series of patients and not a prospective, randomized or controlled study. The treatment decisions were those of the physician or cardiologist in charge of the case and were not assigned. The shortcomings of analysis of retrospective data is well known to the authors and therefore no P-value statistical analysis was attempted, although it would appear that much of the data especially in Table 1 and Table 2 could have withstood such scrutiny. The baseline demographics of our population and the area of myocardial infarction (MI) is essentially identical to the most recently reported article on thrombolysis.[1]

Secondly, it should be pointed out that this study spanned a time period of better than five years when medical therapy, percutaneous transluminal coronary angioplasty (PTCA), or surgical therapy of coronary artery disease changed drastically.

The PTCA equipment technology and techniques changed dramatically, the intra-coronary streptokinase (IC-STK) dosage changed, the IC-STK was replaced almost entirely by intravenous streptokinase (IV-STK) and the selection process of qualified patients also underwent changes. In spite of the above, STK therapy proved to be very effective in reducing mortality. The 4% in-hospital mortality in the IC-STK group includes *all* patients, even those (greater than 50%) who had emergency or elective coronary artery bypass grafting (CABG). Patients with previous MI, CABG, congestive heart failure or cardiogenic shock were not excluded. Even the 7% mortality in the IV-STK group is highly acceptable in view of the 16% to 28% in-hospital mortality for MI reported prior to the advent of thrombolytic therapy.[2]

The seemingly high morbidity figures in this study included quickly corrected arrhythmias, surgical or catheterization site problems, prolonged hospital stays, reocclusion of an opened vessel, and streptokinase allergic reactions. The only serious morbidity related to the procedures was that of hemorrhage and cerebrovascular accident (CVA). The combined hemorrhage and CVA total was 5% in the IC-STK group and 10.8% in the IV-STK group, figures which are comparable to multiple other studies on thrombolytic therapy.

Thirdly, it would appear that your reviewers critiqued this article on the basis of 1988 data, trials, and therapy, and not on the basis of concurrent information available during the period of the study.

The final two paragraphs of the article clearly point out the need for review and dissemination of current data related to ongoing trials of thrombolysis or PTCA in the therapy of acute MI so that physicians may be advised on how to treat their patients appropriately. The cardiologists of the Appleton Heart Institute are evaluating the new data as they arrive, as I'm sure Dr Reinhart and Dr Green are. I am unaware of any series of comparable size reviewed retrospectively or prospectively from the state of Wisconsin that attempts to ascertain whether the use of thrombolytic therapy is useful or safe in the setting of the community hospital or tertiary center. This data, as pointed out by Dr Reinhart, are available in national and international publications, but may not be currently known by most practicing family practitioners or internists. The GISSI trial,[3] for example, included more than 11,000 patients and showed an 18% decrease in hospital mortality in those patients receiving thrombolytic therapy compared to a controlled group not receiving thrombolytic therapy.

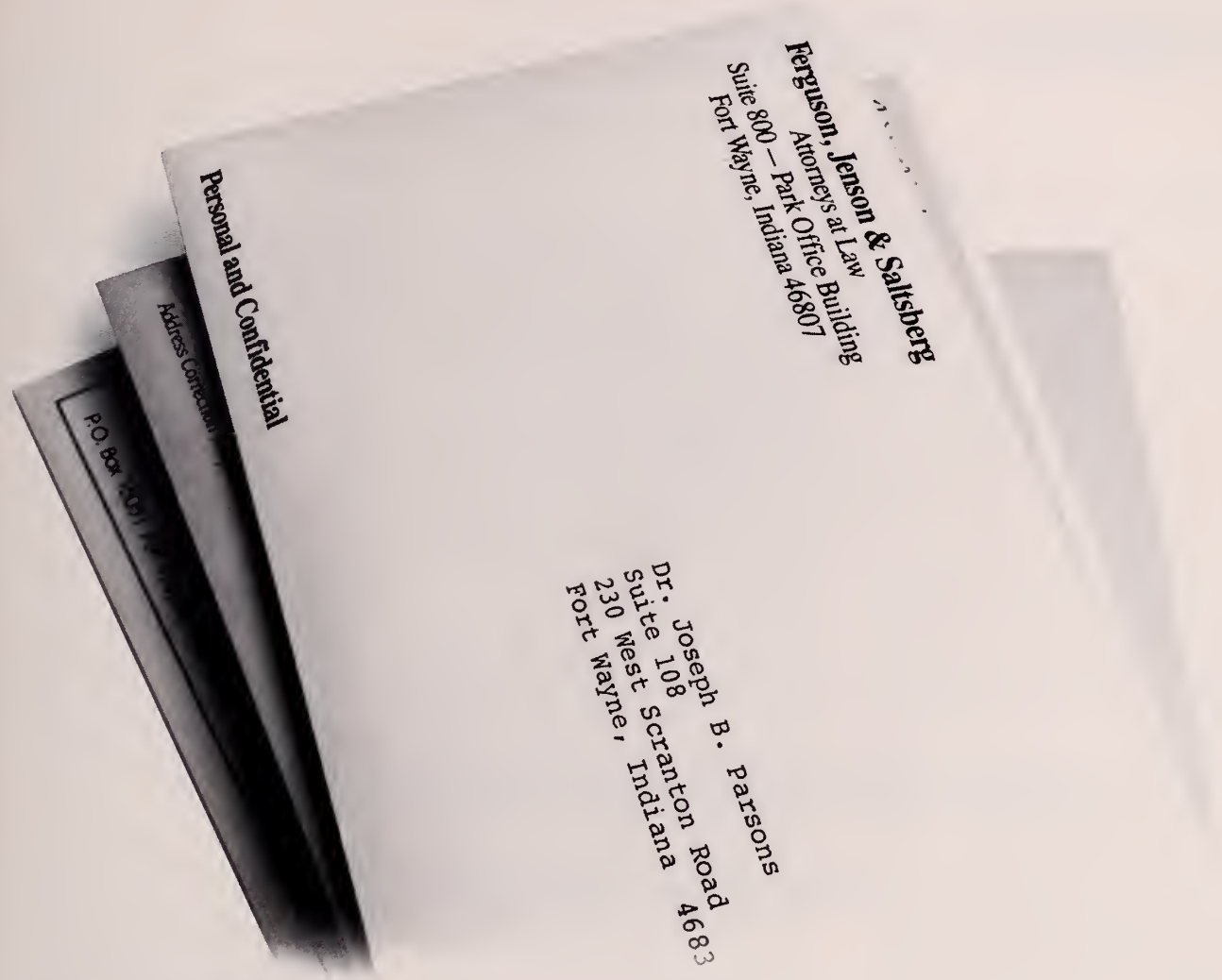
The present article was only meant to show your readers that thrombolytic therapy *works* and that it does save lives and myocardium at an acceptable risk and that physicians in the state of Wisconsin dealing with acute MI patients should familiarize themselves with thrombolytic protocols.

Current information from the literature would suggest that results with IV tissue plasminogen activator (t-PA) should achieve results comparable to or better than IC-STK in the community hospital as well as in tertiary care centers.

—*Lowell F. Peterson, MD*
Appleton

1. Califf RM, Topol EJ, George BS, et al: Characteristics and outcome of patients in whom reperfusion with intravenous tissue-type plasminogen activator fails: Results of the thrombolysis and angioplasty in myocardial infarction (TAMI) I trial. *Circulation* 1988; 77:1090.
2. Kannel WB, Sorlic P, McNamara PM: Prognosis after initial myocardial infarction. The Framingham study. *AM J Cardiol* 1979; 44:53.
3. Gruppo Italiano per lo Studio della Streptochinasi nell Infarcto Miocardico (GISSI): Effectiveness of intravenous thrombolytic treatment in acute myocardial infarction. *Lancet* 1986; 1:397.■

Crisis in black and white.



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SOUNDINGS

Big city clinic

David L. Schiedermayer, MD
Milwaukee

IN THIS CLINIC the hallways are long and the echoes distant. Despite numerous schedule manipulations, patients still wait on hard plastic chairs in the halls. The ceiling is white and there are areas where the tiles show water stains. The walls do not match the ceiling. In the back, where the doctors congregate, there are papers and forms scattered everywhere. There is a form for every purpose, and before an x-ray film or an electrocardiographic study can be done the forms must be completed. In the background there is the buzzing of an old air conditioner. Stained coffee cups, prescription blanks and old lists clutter about the place.

The residents look tired. They are scanning charts preparing to see another patient. Many of the patients have the same types of diseases, diabetes and hypertension, but patients are the redeeming feature of the big city clinic.

There is an 80-year-old man whose son has Down's syndrome and is now 50. The son is overweight and has arthritis of the knees. The father looks young, spare and trim, and appears to be only 10 years older than his son. His purpose in life is caring for his son, and I make the mistake of going in and shaking the father's hand. He corrects me quite bluntly: "The patient," he says, "is over there," and points at his son.

There is a woman who gives me a headache by bringing up so many somatic complaints within a short visit that it overwhelms me. There is a blind man who is just out of jail and says, "You'll never guess why I was in—murder. I bet you don't know how a blind man could murder someone." I say I don't, and he tells me that he strangled his landlady after she threatened to evict him.

There is a rapist's mother with hypertension who is very ashamed of her son's crime. There is a young man with parotid sarcoidosis who thinks he has the mumps. There is a woman who comes in with cervical radiculopathy and is kind, even genteel. There is a group of patients who are seeking either drugs or back-dated work excuses.

There are noncompliant patients and subservient patients. There is a young man with knee pain who is still playing basketball vigorously every night. There are many who come in for hepatitis panels because they would like to give plasma, but the plasma center wants them checked out. They make $6 to $8 a pint for their plasma, so they are very concerned with their earning potential.

They come in with concerns about Pepsi allergies, with cigarette burns, with smelly feet. They come in wearing handcuffs or suits.

They come with arm numbness from playing cards and letting their elbows sit on the table, with angina, with cough, with hemorrhoids, with hoarseness, with arthritis, with AIDS, and with a host of other diseases. Mainly they have diabetes, hypertension, emphysema, liver disease, and other complications of alcohol drinking and cigarette smoking.

When I see them myself, or when I staff the resident who is seeing them, I sometimes lean against the wooden door. I listen to what the patients are saying, and I feel the tones of their voices on my fingers, transmitted through the walls of the small rooms.

Disease is the great equalizer of all mankind: To the most humble it gives a certain measure of dignity and stature. They have *something* they need and deserve to be treated for, and they need the response of modern medicine. This puts them on the same level as an executive. They can talk about it with their friends, pray about it in church, and seek compensation for it through disability. For those with little to begin with, secondary gains look good.

In the big city clinic, patients are treated for several years by the same resident who sees them, evaluates them, and writes prescriptions for them. When that resident moves on to take a practice position or fellowship, they suffer anxiety for a time, waiting to see what the new resident will be like. They display amazing equanimity during the changeover, for they realize that they will be seen by conscientious residents and staff, and that their medical care is first-rate. They will experience the finest in preventative care, cancer screening, and technological procedures.

They receive all of these things in a big city clinic. At night, as the clinic slowly closes, the hall lights dim and the corridors empty as doctors and patients go home. The staff doctors go home to the suburbs, wide open spaces, and quiet gardens. The resident physicians go home to apartments on the fringe of the city. The patients go home to the inner city and blaring sirens. Soon they will meet

Dr Schiedermayer is Assistant Professor, Division of General Internal Medicine, and Associate Director, Center for the Study of Bioethics, Medical College of Wisconsin, Milwaukee. Reprint requests to: David L. Schiedermayer, MD, Center for the Study of Bioethics, 8701 Watertown Plank Road, Milwaukee, WI 53226 (phone 414-257-6040).
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again in the big city clinic, and try again to bridge the gaps and heal the wounds. America's medicine begins here—the quality of this care will reflect on any care that private practitioners give in their offices—for here many are trained. They may scoff at the inefficiency here, but they owe this clinic much.

But in the big city clinics the staff becomes younger and younger, and its turnover more rapid. The conditions around the clinics are more unsafe, and their physical plants continue to deteriorate. Within the residency programs, residents perceive the clinics to be of less value than other experiences. Despite grant money, despite county, state and federal money, the big city clinics are seen as lacking a future, for there is diminishing interest in organized care for the indigent. If the medical school does not support the clinics, if its faculty are not promoted, and if the residents do not see them as a worthwhile endeavor, big city clinics are in trouble.

I am thinking of all these things as I sit in our clinic on a Friday afternoon. It has been a very quiet day and there are only a few residents and patients meeting each other. I have seen several, and staffed a handful, and despite my efforts at teaching enthusiastically and encouraging the residents to continue health-screening measures, the low self-image of the clinic is contagious for the residents and myself. As I struggle with this, we see a patient who has lost 50 lb and maintained good diabetic control, and whose heart failure, ascites, and hypertension are under good control. I compliment the resident and the patient, and find a spark of encouragement here. If I depended only upon good results to encourage me, working in this clinic would be unbearable. Nevertheless, I take encouragement, as do the residents, from such a patient.

There is much to be learned in big city clinics. They are complex places not easily analyzed as components of a teaching program. They deserve more academic time and respect than they now have, despite their faults. Without them, there will be a lot of big city patients and housestaff who miss a great opportunity: To meet in the big city clinic.■

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Medicare: questions and answers

Q. My charge for a limited office visit is $20, but if a patient pays the day of the visit I discount my fee $2. How should I submit my claim to Medicare?
A. If you give your patient a discount, the discounted fee should be submitted to Medicare on the claim form. Please keep in mind that the discounted fee is used in determining your future customary profile. It is possible that your customary charge may go down because of the discounted fee.

Q. One of my office staff submitted 20 claims to Medicare with incorrect CPT codes. What should I do?
A. You must submit corrected claims to Medicare Inquiry Services and write "corrected claim" in red across the top of the claim form. Attach a brief explanation on the claim to clarify exactly what you want changed.

Q. My secretary fills out the HCFA 1500 claim form and I review them for accuracy. If I find an error can we make corrections on the claim form?
A. If you must alter a claim form in any way, you must initial and date box 25. If this isn't done, Medicare will return the claim to you for verification.

Q. I'm new in the office. What type of manuals are available to assist me in submitting claims to Medicare?
A. The CPT and HCPCS manuals contain procedure codes used to describe services. The ICD-9-CM manual contains diagnosis codes. Another manual which is handy to have is CPT and HCPCS Coding for Optimal Reimbursement. This manual goes into more depth and is an excellent reference for new office staff. The Part B reference manual called Medicare in Wisconsin, A Primer for Physician Offices, is also a valuable manual to have in the office. It contains information on claims filing guidelines, reimbursement and much more. The address and cost of each manual is listed below.

CPT 4 manual
Book and Pamphlet Fulfillment:
OP-341/7
PO Box 10946
Chicago, IL 60610-0946
cost: $30.00

HCPCS manual
Medicare Inquiry Services
1717 W. Broadway
PO Box 1787
Madison, WI 53701
cost: free

CPT and HCPCS Coding for Optimal Reimbursement
Medical Administration Publications
PO Box 9268
Downers Grove, IL 60515
cost: $39.95

ICD-9-CM
Volume 3 Procedures—Tabular List and Alphabetic Index
PO Box 971
Ann Arbor, MI 48106
cost: $32.00

Medicare in Wisconsin, A Primer for Physician Offices
State Medical Society
330 E Lakeside St
PO Box 1109
Madison, WI 53701
cost: $15.00 plus tax

Q. How do I submit a claim for multiple surgeries to Medicare?
A. List both surgeries on the same claim form. Reduce your charge for the second surgery 50% and use the 51 modifier. Medicare will approve the full reasonable charge for the first surgery and 50% of the approved amount for the second surgery.

Q. I'm a nonparticipating physician. Can I get a list of items Medicare may deny as not medically necessary?
A. Currently there is no such list, but beginning in the May/June issue of *Communique,* WPS Medicare is devoting a section to this topic. All nonparticipating physicians should review these articles carefully. Your office should begin to keep a list of services Medicare is denying as not medically necessary to refer to when determining when a waiver statement should be signed by your patient.

Q. Is Medicare investigating services before they are denied as not medically necessary?
A. Yes, Medicare will research and make phone calls on these claims if there is a question as to the need for the service. Physicians should make their staff aware of the possibility that they may receive such phone calls and ask that they provide any additional information that may aid Medicare in approving your claim. Keep in mind Medicare is asking for more documentation than what they already have on the claim form.

If you have any questions about Medicare that you would like to see answered in this column, send them to: Medicare Q&A, c/o Karen Lord, State Medical Society of Wisconsin, PO Box 1109, Madison, WI 53701.■

I PAID MEDICARE FOR MY MISTAKE

A Wisconsin physician who learned his lesson

My mistake was not ensuring the accuracy of the Medicare Reimbursement Claims that I was submitting. I left the task of preparing the claim forms to my clerical staff and signed the forms they prepared. Even though I did not intend to take advantage of the Medicare Program, I was held accountable for the improper claims I signed. I have refunded the amount that I was over-paid and paid an additional $65,000.00 in penalties.

DON'T MAKE THE SAME MISTAKE I DID.

This advertisement is being published as part of a Settlement Agreement between a physician client of a Wisconsin Law Office and the United States Attorney's Office for the Western District of Wisconsin. It is designed to inform similarly situated health care providers of the refund and penalty payment in this type of matter and to promote awareness and accuracy in claims for Medicare reimbursement. It is designed to portray the physician's position in this matter.

SMS Sponsors coding for Medicare workshops

Evaluation forms from previous SMS seminars expressed the need for further training with individualized attention and more time for questions. Based on your comments, SMS developed a brand new program called "Coding for Medicare." This one-day workshop is designed to increase medical office staff understanding of CPT coding for Medicare.

Topics include the three levels of HCPCS coding, an overview of the CPT manual, modifiers, multiple surgery and concurrent care guidelines, common coding errors, Medicare review process, and audits.

All levels of office staff will benefit from this program. It features presentations by SMS and WPS staff. You will receive "hands on" experience through individual and group exercises. Time is scheduled for your specific questions. *Please bring your 1988 CPT manual.*

Individualized attention is assured through limited enrollment, advanced seating arrangements with other participants of the same specialty, and a representative assigned to each group.

Registration is at 8:30 AM with the program beginning promptly at 9 AM and concluding by 4 PM. The fee of $75 per person includes lunch, refreshments, and a workbook. We offer an early registration fee of $60 per person to those postmarked no later than Aug 15, 1988. Register early to receive this discount. To attend, each registrant should complete the registration form below.

Cancellations must be received by SMS in writing one week prior to the seminar to obtain a refund. Telephone registrations will not be accepted. Confirmation letters and maps will be mailed two weeks after receipt of your registration. If you have further questions, please contact the SMS Medical Policy and Practice division at 1-800-362-9080 or 608-257-6781, ext. 135.

Registration Form (please print)
Return with your check payable to: State Medical Society, PO Box 1109, Madison, WI 53701.

Name _____ Title _____

Clinic/Organization _____ Specialty _____

Address _____ City _____

State _____ Zip _____ Telephone ( ) _____
area code

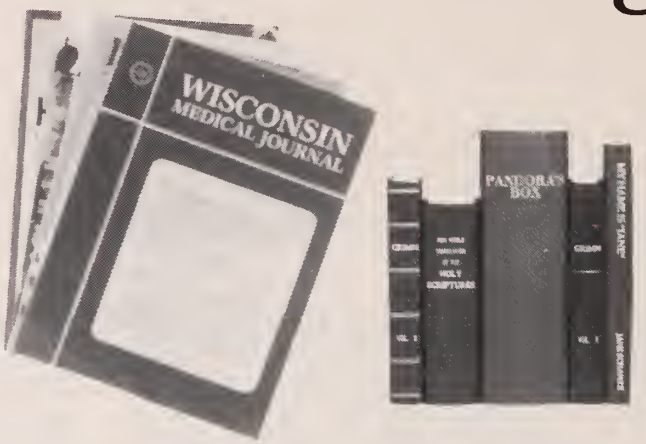
Is your physician an SMS member? _____ Yes _____ No

Please number up to three (3) sites you could attend in order of preference. SMS will do its best to schedule you with your first choice.

Date	Location	Site	Preference
9-8-88	Eau Claire	Civic Center Inn	_____
9-9-88	Stevens Point	Holiday Inn	_____
9-20-88	Milwaukee	Ramada Inn	_____
9-21-88	Milwaukee	Sheraton, Mayfair	_____
9-22-88	Fontana	The Abbey on Lake Geneva	_____
10-11-88	Green Bay	Howard Johnson	_____
10-12-88	Green Bay	Howard Johnson	_____
10-13-88	Neenah	Valley Inn	_____
10-26-88	Madison	Holiday Inn, East Towne	_____
10-27-88	Madison	Radisson	_____

07/WMJ

Cosmetic Surgery



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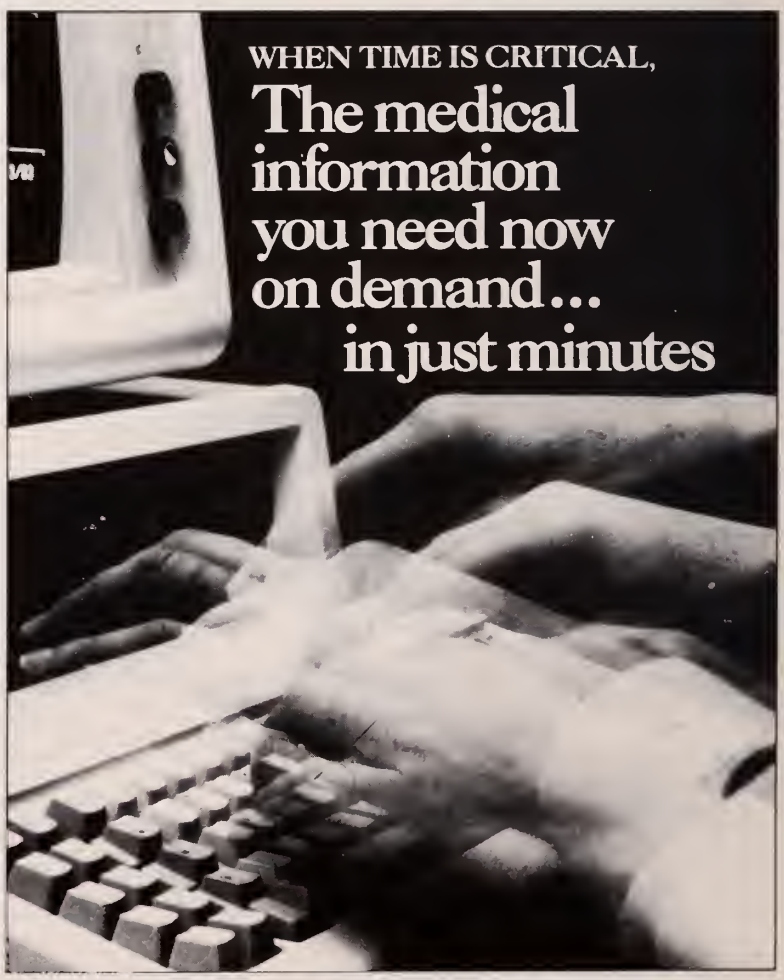

Loss Prevention Corner

The problem patient

The State Medical Society has been receiving numerous questions on how to discharge a patient. Patients who consistently fail to follow medical advice, who display hostility, or who miss too many appointments tend to become liabilities. Physicians should consider whether they are being asked to assume too much of a burden in continuing to treat patients who refuse to cooperate in their own care. Such patients are among the first to consider suing whenever complications occur or when their own unrealistic expectations are not met. Physicians who feel they cannot provide good care because of the patients' lack of cooperation are not legally obligated to continue treating the patients—if they make proper arrangements to withdraw from such cases.

The decision to withdraw from a case must be made with care. The AMA Council on Ethical and Judicial Affairs states that physicians should not neglect the patients, nor withdraw without giving notice to the patients, relatives or responsible friends sufficiently in advance of withdrawing to permit other medical attendants to be secured. The physicians must give the patients proper notice that they are withdrawing and must give the patients reasonable amounts of time to obtain new physicians. What is a reasonable amount of time will depend upon the circumstances of the cases and the availability of other physicians in the area. The SMS suggests that under most circumstances the time set forth be not less than five days. To

provide a record and protect the physicians, letters should be sent to the patients via certified mail, return receipt requested. This issue of the *Wisconsin Medical Journal* contains examples of letters that may be used to discharge patients. *Remember:* It is important to document these behaviors in the medical record. If a patient misses an appointment for an unknown reason, note it in the record. Whenever a patient refuses medical advice, put it in the medical record. The Mutual Assurance Company of Alabama has been successful in causing attorneys to drop claims against some of their insureds because the physicians' medical records contained clear information which refuted the patients' allegations.

What happens, however, when patients refuse to find other medical care providers and threaten to sue if the original physicians do not continue to care for them? Several physicians have contacted the SMS legal staff in the last month with this question. They have sent the letter withdrawing from the case, but the patients refuse to comply. If you have suggestions from your own experiences on how to deal with these difficult patients, please send them to the Division of Medical Policy and Practice and we will print them in the next Loss Prevention Corner. We will also have a response from the SMS legal staff.■

Practice management seminars

SMS has received many requests from members for additional materials and programs to assist physician offices in practice management, especially dealing with third-party payment programs, and has developed a program to meet these concerns. A series of seminars was held in November 1987 on Medicare reimbursements for physicians. These seminars answered questions about the October 1987 changes, as well as chronic concerns and questions on WPS-Medicare policy and procedures. The SMS and WPS-Medicare staff presented useful information on the Medicare billing process, MAAC calculations, profile use, and disclosure form requirements to 900 participants. The SMS scheduled two additional Medicare seminars in March 1988 for those who could not previously attend.. These seminars also quickly filled to capacity.

In addition, the SMS sponsored spring 1988 seminars on EDS-Medicaid billing. Working closely with EDS staff, the SMS held 11 seminars, geographically distributed throughout Wisconsin, to address problems that developed due to EDS's new computer system implemented in January, as well as chronic EDS-Medicaid billing questions.

SMS has retained a practice management specialist, whose responsibility is to develop timely, practical and affordable practice management programs for physicians and their staff. Look for more information on these programs in the *Medigram.*■

Quackery going strong

One in four Americans—some 46 million persons—has used questionable or unproven health treatments for a yearly total cost of more than $2 billion, according to a recent survey commissioned by the US Department of Health and Human Services. Taken by Louis Harris and Associates in the spring of 1986, the survey also says physicians may play an important role in limiting the use of these products.

An executive summary accompanying the survey notes that there is increasing concern among health care professionals that many people may be using dangerous or ineffective treatments. These remedies may cause economic hardship, lead to avoidance of scientifically acceptable treatments, or actually harm the user. Despite growing concern about the problem, however, there has been no accepted estimate of the extent, nature and consequences of the use of these treatments, the summary says.

The survey consisted of a national cross-sectional sample of 1,514 adults, with a subsample of two groups—adults who have had arthritis or cancer. Products were classified in 15 treatment areas as scientifically acceptable or questionable by an advisory group of FDA staff and a consultant.

The DHHS report found that 26.6% of persons questioned had used one or more medical remedies considered questionable. It also found that although the cost to each person for such treatments is relatively small, it is high on a national level—on the order of $2.24 billion annually. The study cautions, however, that these numbers are probably low because only 15 treatment areas were studied and the cost does not count multiple product uses by the same user in the same year. The survey also assumed that each person spent no more than $1,000 for a product per year. (A recent health fraud conference held in Kansas City estimated the total cost of these treatments at $25 billion per year.) Among other results reported by the survey were the following:

- Only one in ten persons who had used a questionable product reported that it was not effective, and one third of users said it was very effective.

- Information about such treatments is most often spread by word of mouth. Three of ten persons surveyed who used these treatments said they first learned about them from friends and neighbors. Half said they in turn recommended the treatment to others.

- Only one in 40 persons (2.5%) reported that the product caused any harm. This relatively low incidence of harmful effects, however, translates into a total of more than 1 million persons in the US who felt they were harmed.

- The poor and the sick are especially at risk to the use of questionable products, but college graduates seemed more likely than those without a degree to use them.

- Persons having the greatest trust in physicians and traditional medicine are least likely to use questionable treatments.

- Most users of these products have never complained to anyone about them. Those who do complain typically do so to a friend or relative, a physician, a retailer, or the manufacturer. None of those surveyed said they had complained to a government agency, a consumer group, or to the news media. It is therefore difficult for public agencies to monitor consumer problems in this area.

- Physicians appear to be one of the most effective points of intervention in the use of these unproven remedies. Although most users say they have not discussed the questionable treatment with their physician, the survey suggests that these persons are likely to see a doctor frequently. The executive summary of the survey recommends that physicians discuss with their patients the self-treatment remedies and medications they are using. "This is probably the single most effective way of intervening in the pattern of use of the questionable treatments observed in the survey," the summary says.

The Louis Harris poll also investigated the use of questionable treatments for two diseases—arthritis and cancer. According to the survey, more than a third (36%) of arthritis sufferers have used questionable treatments, the most common being vitamins, vibrators, and special diets. Other treatments tried by this group included alfalfa tablets, copper bracelets, DMSO, and acupuncture. Slightly more than one fourth of those in the arthritis group reported that these treatments were somewhat effective, well below the perceived effectiveness rate for the survey group as a whole.

Only 15% of cancer victims reported using unproven remedies for their disease, and of those who did, few (10%) thought it was very likely that the treatment would cure them. Slightly less than a quarter said the treatment was somewhat effective.■

An Angell in our midst

by Earl R. Thayer, former secretary-general manager of SMS

When her boss, the late Charles Crownhart, characterized her as "an angel in our midst," his pun intended more respect than humor.

Mary Angell has had a distinguished career of editing and publishing one of the finest state medical journals in the nation—the *Wisconsin Medical Journal,* the official publication of the State Medical Society of Wisconsin. And Mary never forgot to remind everyone, including herself, that the emphasis was on *the official* publication of the Society. No doubt that accounts for the high regard in which she is held by fellow medical journal editors, the physicians associated with the *Wisconsin Medical Journal* editorial boards over three decades, Society staff, and a host of others in and out of medicine who have had dealings with this outstanding woman.

Mary Angell spent 13 years in advertising and office management for the Upper Des Moines Publishing Company, which published a large weekly newspaper in Algona, Iowa, before coming to the State Medical Society in 1958 as editorial assistant for the Journal. She quickly established her competence and captured the confidence of her co-workers in the Society. Mary became assistant managing editor of the *Journal* in 1963. She held this position for 17 years, although she was by fact of duties and responsibility the managing editor. Only a nationwide quirk of tradition that medical society chief executives hold both positions, even though managerially outmoded, kept Mary from assuming the title to which she was proper heir until 1980.

Mary L. Angell retired as managing editor of the Wisconsin Medical Journal *at the SMS Annual Meeting in April.*

Mary had a penchant for detail. She had an eye for error, whether of thought or word. The misspelled word, the wrongly-placed decimal point, the thoughtless transposition of medical terms or phrases—each caught her attention. In a medical journal widely read and used for improving treatment techniques, failure to catch such errors could have tragic consequences. Many a physician author or staff writer was saved embarrassment by her discerning eye. Her scientific editing won respect.

Mary's contributions went far beyond the *Journal,* however. Early in her Society career she was charged with, in addition to her editing duties, major staff responsibility for the administration of the State Medical Society's Charitable, Educational and Scientific Foundation. She took great interest in every aspect of the Society's activities. Sometimes she had to push her way into Society affairs that were thought to be her "business" only in the sense that the Journal was both archive and media.

It is little wonder then that Mary quickly became a major resource for physicians who sought scientific and historical information, for staff (particularly newcomers) who needed background, for outsiders who needed some inside information on medicine and the Society. She was a resource on who was who in the specialties and specialty societies, on state health agencies and their officials, and on physicians, state and nationwide. She selflessly shared her talent for writing and art with countless staffers and consultants, most particularly those who served in public information or public relations capacities for the Society over the years.

Mary had a special compassion for any and all who had problems or needed a sympathetic ear. She had a quick and effervescent humor to brighten any day or ease any situation. She was generous with suggestions to improve the organization, to aid the purposes of the medical profession, and to help others.

Mary's retirement, coming exactly 30 years after she began with the *Journal,* was highlighted at the State Medical Society's annual meeting on April 28 when she received the Society's 1988 Meritorious Service Award for "outstanding contributions to medicine and to the State Medical Society of Wisconsin."

A fitting tribute to "an Angell in our midst."■

NEWS HIGHLIGHTS

Children die from pepper aspiration

A recent report in the *American Journal of Diseases of Children* describes eight cases in which children died of pepper aspiration. Seven of the deaths resulted from homicide child abuse and one was accidental, according to the authors, who are with the Blodgett Memorial Medical Center in Grand Rapids, Mich. The reports came from a number of states and involved children ranging in age from 5 months to 10 years. The homicides, in which the children were forced to eat pepper, were similar to conventional child abuse cases: in each instance, the child was being punished, four of the seven assailants initially gave incorrect histories, and four children were chronically abused.■

Number of physicians to rise 22%

The number of active physicians in the US will increase by 21.9% by the year 2000, according to a report from the AMA's Center for Health Policy Research. Entitled *Physician Supply and Utilization: Trends and Projections,* the report projects that the active physician population will increase from 519,400 in 1986 (the last year for which data are available) to 633,200 in the year 2000. The number of women physicians will increase by 91.9%, compared to a projected 9.2% increase among men, the study says.■

Physician washes out of practice

An anesthesiologist in Hudson, Mass, says he is giving up his practice to run a self-service laundry and dry-cleaning business because it carries a lot less liability than medicine. According to a recent article in the *Milwaukee Journal,* Joseph J. Merigo, MD, 57, left his 20-year practice in March to operate the Hudson Coin-Op because of high insurance rates and the threat of being sued. "When doctors have a malpractice suit, it's a $3 million to $5 million loss. If someone's laundry doesn't come out right, I just pay them the $40 or so to cover it and it's done," Dr Merigo is reported to have said. Dr Merigo, who had practiced anesthesiology part-time in Boston-area hospitals, said his annual professional liability premiums were just about equal to his income, although he had never been sued.■

A call for photographs

The *Wisconsin Medical Journal* and the SMS Charitable, Educational, and Scientific Foundation are joining forces in an effort to build a photographic library of medicine in Wisconsin. Donations of current or historical photos relating to medicine—persons or places, equipment or events—are welcome and tax deductible. All donated photos will become the property of the Fort Crawford Medical Museum, which is owned and operated by the foundation, and may be used to illustrate future issues of the *Wisconsin Medical Journal.* Send your photos to: Kristin Bjurstrom Krueger, Director of Foundation Activities, State Medical Society of Wisconsin, PO Box 1109, Madison, WI 53701-1109.■

Mumps immunization required of all students

The Department of Health and Social Services (DHSS), beginning with the 1988–1989 school year, will require all students through grade 12 to meet the state's mumps immunization requirements. Since 1983 only students entering kindergarten have had to present proof of immunization or evidence for a medical, religious or personal conviction waiver; DHSS earlier this year changed the administrative rule on immunizations to extend the mumps requirement to all students through grade 12.

According to Jeffrey Davis, MD, state epidemiologist, Wisconsin had the highest incidence rate for mumps in the US last year with 36.2 cases per 100,000 population. The national incidence rate was 5.1 cases per 100,000. In 1987, 1,741 cases of mumps were reported in the state compared to 325 cases in 1986. Dr Davis estimates that 81,000 Wisconsin students in grades five through 12 are susceptible to the disease.

Dr Davis said school principals will notify parents whose children do not have proof of mumps immunization on their school records.■

Wisconsin hospital costs rank near bottom in US

Wisconsin hospitals last year ranked 45th in the US in average cost per hospital stay and 44th in the average daily charge, according to a recent survey conducted by Equicor, a joint program of the Equitable Life Assurance Society and the Hospital Corporation of America. The average cost of a hospital stay in Wisconsin in 1987 was $3,119, and the average cost per day was $552, the survey said.■

SMS Policy analyst launches bid for Assembly

Frank Vogel, an SMS policy analyst for the past two years, announced his candidacy in the Democratic primary for the 85th Assembly seat on June 10 in Wausau. Vogel most recently served as program manager for PartnerCare, the SMS cosponsored voluntary Medicare assignment program for low-income senior citizens. He will feature health care as a primary focus for his campaign.

"Frank's candidacy exemplifies the public spirit called for by member physicians," said SMS Secretary-General Manager Thomas L. Adams. "Representing our patients' health and physicians' legislative concerns is the top priority identified in the SMS Strategic Plan and adopted by the 1988 House of Delegates." In addition to his PartnerCare duties, Vogel staffed the SMS Committee on Health Care Quality, Costs, and Utilization. He also represented the Society on the Community Options Program (COP) Statewide Advisory Committee and on the Wisconsin Maternal and Child Health Coalition. COP enables the elderly and the disabled to live independently in their communities.

Before coming on board at SMS in 1986, Vogel served as an analyst for the state Department of Revenue and the state Department of Health and Social Services.■

Frank X. Vogel

*Physician members of the State Medical Society of Wisconsin

PHYSICIAN BRIEFS

Rainer Richeleau, MD, recently joined the medical staff of the Midelfort Clinic's Chippewa Falls office. Dr Richeleau received his medical degree from the University of Minnesota. He served an internship at St Mary's Hospital in Duluth and a residency in obstetrics and gynecology at St Paul-Ramsey Hospital in St Paul, Minn.

Lawrence Reich, MD, has joined the staff of St Agnes Hospital in Fond du Lac as an emergency room physician. Dr Reich graduated from the University of Wisconsin Medical School in Madison and completed an internship at the Tucson Medical Center and Pima County General Hospital in Ariz. He most recently served as an emergency physician at St Elizabeth's Hospital in Appleton, the Appleton Medical Center, and the Mercy Medical Center in Oshkosh.

Donald E. Koepke, MD,* of Milwaukee, was a recipient of the 1988 Golden Trumpet Award from the Centurions of St Joseph's Hospital. The award is presented each year to persons who have made significant contributions to St Joseph's Hospital and the health care community. Dr Koepke, who recently retired from practice as a thoracic and cardiovascular surgeon, was honored for his role in the development of the hospital's cardiac care center. A volunteer group of local business people, the Centurions sponsor fund raising and other events promoting the hospital.

Paul E. Hankwitz, MD,* of Whitefish Bay, has joined the Northwestern Mutual Life Insurance Company as assistant medical director. Before joining Northwestern, Dr Hankwitz was in private practice and on the staff at Columbia Hospital. He received his degree from the Medical College of Wisconsin in Milwaukee.

Raymond J. Zastrow, MD,* has joined the staff of the Northwest Milwaukee Physicians Group. A

family specialist, he received his degree from the Medical College of Wisconsin and served a residency at the University of North Carolina. He is a diplomate of the American Board of Family Practice.

Norman O. Becker, MD,* retired recently after nearly 40 years of practice in Fond du Lac. A native of the area, Dr Becker received his degree from the University of Wisconsin Medical School in Madison. He established his practice in 1949 after serving in the Navy and completing a residency at Western Reserve University in Cleveland. A member of the Board of Governors of the American College of Surgeons from 1974 to 1980, Dr Becker is a past president of the medical staff and chief of surgery at St. Agnes and is past president of the Wisconsin Surgical Society and the Fond du Lac County Medical Society.

Paul D. Johnston, MD, has joined the staff of the Marshfield Clinic at the Durand Center. A native of Barron, Dr Johnston received his degree from the Medical College of Wisconsin in 1985.

Milton F. Stuessy, MD,* a Platteville physician for the past 27 years, recently retired from practice with the Doctors Park Physicians group. A native of Platteville, Dr Stuessy received his degree from the University of Wisconsin Medical School in Madison.

Lynn E. Shallberg, MD,* and **L. Edelmina D. Santiago, MD,*** both pediatricians, have joined the staff of Medical Associates in Waukesha. Dr Shallberg recently completed two years as a missionary in Haiti, and Dr Santiago finished up a three-year residency at Michigan State University in East Lansing.

Arlinda Hildebrand, MD, has joined the staff of the Ramsey Clinic in Osceola. A specialist in obstetrics and gynecology, Dr Hildebrand received her medical degree from the University of Minnesota and completed an internship at St Paul-Ramsey Medical Center in St Paul, Minn.

Samuel G. Perlson, MD,* of Milwaukee, recently assumed the presidency of the Wisconsin Medical Alumni Association. **Herbert F. Sandmire, MD,*** of Green Bay, was chosen president elect. Dr Perlson, who graduated from the University of Wisconsin Medical School in 1951, completed a residency in obstetrics and gynecology at the university and was clinical associate professor of obstetrics and gynecology at both the UW and the Medical College of Wisconsin. He has served as president of the Milwaukee Gynecological Society and the Wisconsin Society of Obstetrics and Gynecology and was chairman of the Department of Obstetrics and Gynecology at St Michael's Hospital in Milwaukee. Dr Sandmire graduated from the University of Wisconsin Medical School in 1953 and served a residency in obstetrics and gynecology at the University of Iowa. He was the initial preceptor-in-charge for the Green Bay Preceptorship and is a clinical associate professor at the UW Department of Family Medicine. He is also a past president of the Wisconsin Society of Obstetrics and Gynecology and has served on the SMS Commission on Public Information and the Maternal Mortality Committee. He is currently a member of the SMS Committee on Medical Liability.

Susan F. Behrens, MD,* of Beloit, has been named president elect of the Federation of State Medical Boards. A graduate of the University of Wisconsin Medical School, Dr Behrens was recently appointed to the state Medical Examining Board by Gov Tommy Thompson.

Bassem Rimlawi, MD, recently joined the Columbus Community Hospital and the Columbus Clinic. A native of Lebanon, Dr Rimlawi received his medical degree at the American University in Beirut and completed a residency at Cleveland Metropolitan General Hospital. He is board certified in obstetrics and gynecology.

Phillip Ferderbar, MD,* has joined the medical staff at the Germantown Family Practice Clinic. A graduate of the Medical College of Wisconsin, Dr Ferderbar is a family practitioner and has served residencies in obstetrics and gynecology and anesthesia.■

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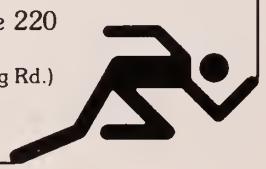

AMA Physician's Recognition Award Recipients

LISTED BELOW are those physicians in Wisconsin who have earned the AMA Physician's Recognition Award in recent months. The State Medical Society of Wisconsin congratulates these physicians who have distinguished themselves and their profession by their commitment to continuing education:

MAY 1988

*Danforth, R Clarke, Milwaukee
*Dean, Russell Allyn, Greenwood
*Dyer, Richard K, Manitowoc
*Gahl, Robert A, Two Rivers
*Garber, Bradley G, Fairchild
*Gehring, John V, Green Bay
*Gruesen, Robert A, Marshfield
*Handler, Bruce, La Crosse
*Hoy, Edward J, Watertown
*Johnson, Steven J, Prairie du Sac
Koepsell, James D, Milwaukee
Landay, Stuart P, Madison
*Levin, Jules D, Milwaukee
Lloyd, Maryann E, West Allis
*Matzke, Rudolf W, Spooner
*Merlis, Anthony L, Madison
*Montemurro, Angelina M, Kenosha
*Nordholm, Vincent W, Stoughton
*Norman, Stanley G, Eau Claire
*Oujiri, John C, Ashland
*Pawlak, James R, Cleveland
*Roehmholdt, John M, Madison
*Saarinen, David M, Ashland
*Sulas, Leonas P, Portage
*Thompson, Teddy L, La Crosse
Welter, Timothy M, Marshfield
*Williamson, Warren H, Racine

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OBITUARIES

Albert P. Graham, MD, 83, former Neenah physician, died March 17, 1988, in Clearwater, Fla. Born Jan 2, 1905, in Early, Iowa, Dr Graham graduated from the University of Nebraska Medical School and served his internship at the University of Iowa Hospitals. During World War II, he served in the Veterans Administration in Leavenworth, Kan; Springfield, Mo; Columbia, SC; and Hinsdale, Ill. Dr Graham, a urologist, was on the medical staffs at Theda Clark Regional Center, St Elizabeth's Hospital in Appleton, and the New London Community Hospital. He also was on the staff at Mercy Medical Center, Oshkosh, Appleton Memorial Hospital, and the Winnebago Mental Health Institute. Dr Graham had served as president of the Wisconsin Urological Society. He was a member of the Winnebago County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Selma; two daughters, Nancy Grosnick, Appleton, and Alberta Barkelar of Oshkosh; and one son, Robert, Naples, Fla.

Arthur D. Bussey, MD, 77, Port Charlotte, Fla, formerly of Wauwatosa, died March 23, 1988, in Port Charlotte. Born Nov 7, 1910, in Milwaukee, Dr Bussey graduated from Marquette University School of Medicine and served his internship at Milwaukee County General Hospital. His residency in ophthalmology was completed at the University of Illinois Research Hospital. Dr Bussey was on the medical staff of St Joseph's Hospital and was a former clinical instructor of ophthalmology at the Marquette University Medical School. He was a member of the Milwaukee Ophthalmology Society, Wisconsin Academy of Ophthalmology, and American Academy of Ophthalmology. He also was a member of The Medical Society of Milwaukee County, the Fifty Year Club of the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Henrietta; one son, Robert, West Bend; and three daughters, Mary Terese of North Liberty, Iowa; Dorothy Zalewski and Judith Gorman, both of West Bend.

Steve L. Chojnacki, MD, 77, Milwaukee, died April 3, 1988, in Milwaukee. Born Aug 31, 1910, in Milwaukee, Dr Chojnacki graduated from Marquette University School of Medicine and served an internship and residency at Milwaukee County General Hospital. Dr Chojnacki served as chief-of-staff at St Luke's and St Francis hospitals in Milwaukee. He served as president of the American Academy of General Practitioners and of the Catholic Physicians Guild. He also served as a councilor of the State Medical Society for nine years. Dr Chojnacki was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Signe; seven sons, Stanley, John, David, Joseph, Steven, Thomas, Gregory; and four daughters, Ruth, Catherine, Signe, and Mary. Also surviving are 34 grandchildren.

William J. Beckfield, MD, 67, former Eau Claire physician, died April 4, 1988, in Eau Claire. Born Aug 25, 1920, in Pittsburgh, Pa, Dr Beckfield graduated from the University of Pennsylvania School of Medicine and completed his internship and residency at Philadelphia General Hospital. He served as a captain in the US Army Medical Corps in World War II. He was chief of surgical pathology at Philadelphia General Hospital and also taught at the University of Pennsylvania School of Medicine from 1952 to 1962. Dr Beckfield joined the medical staff of Luther Hospital, Eau Claire, in 1962 and became director of clinical laboratories in 1967. He served as chief of the hospital's medical staff in 1972–1973. Dr Beckfield retired in 1986. He was a member of the Eau Claire-Dunn-Pepin County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Elizabeth, and eight sons: John, Salem, Ore; Lawrence, Shippenburg, Pa; Thomas, Grand Rapids, Mich; David, William A., and Mark, all of Eau Claire; Patrick, Minneapolis, Minn; and Timothy of Madison.

Kermit W. Covell, MD, 77, Racine, died Feb 11, 1988, in Racine. Born Aug 5, 1910, in Steuben County, Ind, Doctor Covell graduated from Indiana University School of Medicine and served his internship at Cleveland City Hospital. His residency was completed at Duke and Cleveland hospitals. Dr Covell served in the European theatre during World War II. He was a member of the Racine County Medical Society, State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Evelyn; two sons, John and Richard; and a daughter, Mary.

Cecil A. Morrow, MD, 86, Kenosha, died March 23, 1988, in Kenosha. Born March 10, 1902, in Ansonia, Conn, Doctor Morrow graduated from Rush Medical College, Ill, and served his internship at St Mary's Hospital in Madison. Dr Morrow practiced medicine in Viola, Wis,

until 1948. After completing a residency in allergy in Cleveland, Ohio, he returned to Kenosha and retired in 1972. He was a member of the Wisconsin Allergy Society, Kenosha County Medical Society, State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Louise; a son, J.B. Morrow, Grays Lake, Ill, and a daughter, Mrs John (Susan) Chapel of Pewaukee.

Eldon Grady Mills, MD, 63, Green Lake, died April 23, 1988, in Oshkosh. Born Nov 14, 1924, in Poplar Bluff, Mo, Dr Mills graduated from Washington University School of Medicine, St Louis, Mo, and served an internship at St Paul Hospital in Dallas, Tex. He also served residencies at the University of Michigan and Harvard University Childrens Hospital Medical Center. Dr Mills served in the United States Air Force from 1942 to 1946. Dr Mills was chairman of the Marshfield Clinic's Department of Family Medicine retiring in 1986. He was a member of Wood County Medical Society, State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Elizabeth; two sons, Harry, Denver, Colo; Matthew, Los Angeles, Calif; and one daughter, Martha Ellen Kane of Dallas, Tex.

E. Allen Miller, MD, 77, former Watertown physician, died April 27, 1988, in LaJolla, Calif. Born Feb 15, 1911, in Kewaskum, Dr Miller graduated from Northwestern University Medical School, Chicago, Ill, and served an internship at Michael Reese Hospital in Chicago. His residency was completed at Mercy Hospital, Baltimore, Md, and at Johns Hopkins Hospital. Dr Miller practiced medicine in Watertown from 1939 until he retired in 1975. He was a member of the Jefferson County Medical Society, State Medical Society of Wisconsin, and American Medical Association. Surviving are his widow, Ardis; one son, Dr Edward J., Las Vegas, Nev; and two daughters, Mrs Anne Moore, Ithaca, NY, and Mrs Straty Righellis of Piedmont, Calif.

Ben Spaulding Hill, MD, 92, Kenosha, died May 4, 1988, in Kenosha. Born May 19, 1895, in Stanford, Ky, Dr Hill graduated from Jefferson Medical College, Philadelphia, Pa, and served an internship at Walter Reed Hospital, Washington, DC. His residency was completed at Bellevue Hospital in Pittsburgh, Pa. Dr Hill joined the Kenosha Clinic in 1925 and in 1934 went into private practice retiring in 1969. He was a member and past president of the Kenosha County Medical Society, a member of the State Medical Society of Wisconsin, and American Medical Association. Surviving is a daughter, Mrs Donald (Mary) Crowley of Scarsdale, NY.■

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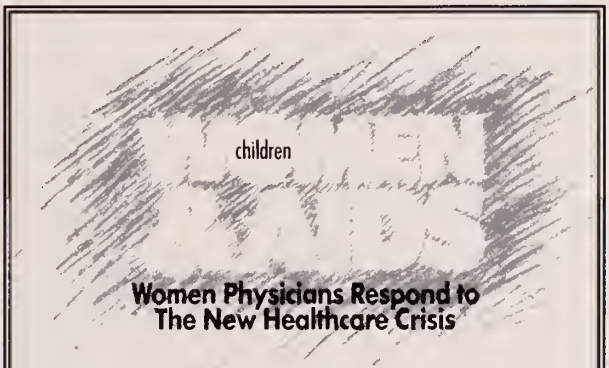

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There's something for you at the 73rd Annual Meeting of the American Medical Women's Association. It's at the Fairmont Hotel in Chicago in a long-weekend format November 4-6, 1988. Call 212/353-3822 to register or to find out more. On site and daily registration available, too.

AMWA American Medical Women's Association
465 Grand Street, New York, NY 10002

PHYSICIANS EXCHANGE

Psychiatrist/Chemical Dependency. Psychiatrist interested in chemical dependency needed to join 220-physician multispecialty group with adjacent 447-bed hospital. Position includes inpatient services for Chemical Dependency Unit with full range of outpatient chemical dependency services available: Evaluation and Detoxification Unit, outpatient chemical dependency clientele and followup, and general psychiatric practice also available. Behavioral Medicine Department is presently staffed by seven psychiatrists, one child/adolescent psychiatrist, and two psychologists. New clinic building recently completed. Gundersen Clinic, Ltd, is located in La Crosse, Wisconsin, a progressive community of 50,000 built along the shores of the Mississippi River amid scenic bluffs. The city offers excellent recreational facilities. Numerous educational and cultural opportunities are provided by an expanding university with undergraduate and graduate degree programs, and a private liberal arts college. Excellent pension program, no investment required. Service organization. Write Philip J. Dahlberg, MD, Chairman, Personnel Committee, Gundersen Clinic, Ltd, 1836 South Ave, La Crosse, WI 54601. An Equal Opportunity Employer. 7/88

Family Practice. Marshfield Clinic is seeking BE/BC family practitioners to join its expanding department in Marshfield. The department is currently staffed by five family practitioners with plans to add three additional members. With the exception of obstetrics, which is done by staff obstetricians, the practice offers a full range of inpatient and outpatient services. Full specialty consultation is readily available in-house. Our community of 20,000 offers strong economic stability combined with exceptional recreational, cultural, and educational opportunities. We offer a current starting salary up to $85,000 with salary in two years up to $110,000. Fringe benefit package outstanding. Send CV and references to David L. Draves, Department of Administration, 1000 North Oak Ave, Marshfield, WI 54449 or call collect (715) 387-5376. 7/88

RATES: 50¢ per word, with a minimum charge of $20.00 per ad. BOXED AD RATES: $25.00 per column inch. *All ads must be prepaid.*

DEADLINE: Copy must be received by the 15th of the month preceding month of issue; *eg,* copy for the August issue is due July 15. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 1-800-362-9080.

Iowa-Decorah, located in northeastern Iowa, near the Minnesota, Wisconsin borders, is seeking a BE/BC psychiatrist. The opportunity exists to establish a solo practice with plans of adding an additional psychiatrist within a year. Brand new psychiatrist unit to be completed shortly. Located 70 miles outside of Rochester, Minnesota, and 60 miles from La Crosse, Wisconsin, Decorah, home of Luther College, covers a six-county area with a service population in excess of 125,000. Excellent guarantee with benefits, additional compensation through the CMHC for contractural services. **Wisconsin**—Scenic lake country. St Mary's in Rhinelander, Wisconsin, is seeking a BE/BC second psychiatrist. General adult psychiatrist with subspecialty interests in child/adolescent preferred. St Mary's is a 150-bed facility with a 20-bed psychiatric unit. Complete psychiatric medical staff. Excellent guarantee with benefits. **Wisconsin-Reedsburg,** 50 miles outside of Madison, is seeking a third adult psychiatrist. The incoming psychiatrist may establish a private practice with the two current psychiatrists in the community or choose to establish an association with the Madison Psychiatric Associates. Excellent guarantee with benefits. Contact: Jean Ecos, 15975 W National Ave, New Berlin, WI 53151; ph (414) 784-2777 (collect). 7-8/88

Immediate opening. One internist to head the Medical Services at a 250-bed acute treatment psychiatric hospital, JCAH approved, Medicare certified, affiliated with the University of Iowa Medical College. Forty-hour work week. No night or weekend on call. Situated in picturesque northeast Iowa near large cities with cultural advantages. Ideal for family living. Golf club, hunting and fishing area, good schools, etc. Salary to $81,012. State law protects employees against malpractice. State pension plan. Unique deferred annuity plan. Generous sick leave and vacation. Write or call collect B.J. Dave, MD, Superintendent, Mental Health Institute, Independence, IA 50644; ph (319) 334-2583. An Equal Opportunity/Affirmative Action Employer. 7-8/88

Family Practice physician wanted to be associated with branch clinic of a large multispecialty group. Opportunity for family practice in Prairie du Chien, Whitehall, Viroqua or Tomah, Wisconsin; West Union, Iowa. Physician would be associated with a multispecialty group. Relief provided for vacations, meetings, etc. Educational opportunities through an excellent education program. Beautiful countryside, cultural, and recreational facilities. Excellent fringe benefits. Salary commensurate with background and experience. Write or call Tim Skinner, MSEd, Family Practice Representative, Gundersen Clinic, Ltd, 1836 South Ave, La Crosse, WI 54601. Equal Opportunity Employer. 7/88

An academic professional staff position for a primary care physician is available at the University of Minnesota Boynton Health Service, a comprehensive out-patient facility serving a population of 40,000 students, faculty and staff on the Twin Cities campus. Eighteen full-time equivalent physicians, four nurse practitioners, and 15 registered nurses are on staff. The physician would be seeing patients in our General Outpatient Clinic on an appointment basis and on a walk-in basis in Urgent Care. Specialty consultations available on-site. Lab and x-ray facilities also are available on-site. Continuing medical education, quality assurance review and clinic accreditation provided. The position requires an MD degree, board certification or eligibility in a primary care specialty, and license to practice in Minnesota. Must have a broad range of medical abilities and relate well to an educated, health-conscious clientele. Salary competitive and commensurate with training and experience. Regular hours and excellent fringe benefits including paid professional liability insurance. Position available immediately but no later than September 16, 1988. Please send resume and names of three references by July 1, 1988 to Donald Severson, MD, Chair, Physician Search Committee, University of Minnesota, Boynton Health Service, 410 Church Street, SE, Minneapolis, Minn 55455. For further information call Dr Severson at (612) 624-2933. The University of Minnesota is an equal opportunity educator and employer and specifically invites and encourages applications from women and minorities. 7/88

Family Practice—Madison, Wisconsin. Eleven-year-old staff model HMO has a family practice position available. We offer a very attractive practice setting with reasonable scheduling, excellent salary, and benefits. Contact John Hansen, MD, Medical Director, Group Health Cooperative, One South Park, Madison, WI 53715; ph (608) 257-9700. 7-9/88

Several outstanding California practice opportunities in OB/GYN, Urology, GI, Cardiology, Pulmonary Disease, General Internal Medicine and FP. As retained consultants to quality hospitals, HMOs and group practices in northern and southern California, we can discuss each practice in detail. Please call or send a CV for additional information. Confidentiality is assured. Contact Ken Baker at (415) 981-7424 (collect). Robert Grant Associates, Inc, "Physician Advocates," 50 California St, Suite 400, San Francisco, CA 94111. 7/88

Physicians needed full- or part-time to perform light physicals. Milwaukee area. Professional liability provided. Phone 414/344-2100, Ms Jenkins. 10tfn/84

PHYSICIANS EXCHANGE

continued

Pediatrician and **General Internist** or Family Practitioner (husband/wife team?) for multi-specialty clinic 50 miles southeast of Chicago in university town in Dunes County of southern Lake Michigan. Superior schools, many recreational opportunities, small town atmosphere. Pediatrician to join long established pediatrician with extensive practice. Four minutes from 400-bed hospital with NICU, ICU, and CCU. Contact Thomas Covey, MD, FAAP, 219-462-4167.
p5-7/88

MEDICAL DIRECTOR

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Blue Cross & Blue Shield United of Wisconsin has a proud tradition of excellence. We are seeking a physician for the position of Medical Director to join our aggressive management team. We are a nationally recognized leader and offer a wide range of employee benefit products. Medical management programs range from Compcare, the state's largest HMO, to our Preferred Provider Organization and fee-for-service products with managed care.

The successful candidate for this appointment will be a physician with a strong background in Internal Medicine or General Practice, and will have demonstrated communication skills. Previous experience serving as an HMO Medical Director and knowledge of utilization review, medical review, and quality assurance is desirable.

The physician will have a vital role in planning and establishing goals and policies for our medical management departments. The physician will provide the medical expertise for all medical review activities pertaining to utilization review, quality assurance, and medical review of complex claims. This highly visible position involves contacts with the provider community on a variety of medical issues.

We offer a competitive salary and benefit package. Please reply in complete confidence to:

Plan Medical Director
Search Committee
Attention: Employment Services
Blue Cross & Blue Shield
United of Wisconsin
401 West Michigan Street
Milwaukee, Wisconsin 53203
6-7/88

Minnesota. Orthopedic Surgery partnership opportunity in central Minnesota, fine living environment, near lakes, two-hour drive to Minneapolis/St Paul. Position carries excellent first-year income and benefit package. Contact Robert Suleski, 250 Regency Court, Waukesha, WI 53186; 1 (800) 338-7107 or (414) 785-6500 (collect in Wisconsin). 7/88

General Internist. Marshfield Clinic, a 260-physician multispecialty group practice, is seeking BE/BC general internal medicine specialists to join its expanding department in Marshfield, Wis. The department is currently staffed by 23 general internists with immediate plans to add seven or more additional members. The current call schedule is generally one night per month and one out of five weekends. An Internal Medicine Residency Program, University of Wisconsin Medical School Affiliation, Medical Research Foundation, and ongoing new developments, *ie,* Geriatrics Evaluation Center and Walk-In Medicine, contribute to a very stimulating environment. Our community of 20,000 offers strong economic stability combined with exceptional recreational, cultural, and educational opportunities. We offer a current starting salary up to $85,000 with salary in two years up to $110,000. Fringe benefit package outstanding. Send CV and references to David L. Draves, Department of Administration, 1000 North Oak Ave, Marshfield, WI 54449 or call collect (715) 387-5376. 7/88

Family Practice (BC/BE) opportunity to join a five-physician family practice group in south central Wisconsin city of 15,000. Pleasant community atmosphere within 1-1½ hours of Madison and Milwaukee. Excellent recreational area. First year guaranteed salary. Contact: Chad Burchardt, Business Manager, Medical Associates of Beaver Dam, SC, 1200 N Center St, Beaver Dam, WI 53916; ph (414) 887-7101. p6-8/88

ORTHOPEDIC SURGEON
NEUROSURGEON
PHYSIATRIST
Industrial Rehabilitation

Outpatient orthopedic clinic seeking additional physicians to join growing industrial rehabilitation center specializing in disability evaluation, treatment, medical management, functional capacity assessment, work-hardening programming and employer consultation services. Part-time and full-time opportunities. Excellent guaranteed salary with incentives plus excellent fringe benefits. Please send CV to:

Bone & Joint Surgery Associates
Chiron Rehabilitation Clinic
2704 Marshall Court
Madison, Wisconsin 53705
(608) 231-3030 7-9/88

Rheumatologist—the Racine Medical Clinic a 34-physician multispecialty group conveniently located between Chicago and Milwaukee. Well equipped clinic offering salary guarantee with incentive bonus; excellent fringe benefits and early ownership. Please send curriculum vitae to: R D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 11tfn/87

Internal Medicine. Board-certified or eligible to join five general internists in a multispecialty group in northeastern Wisconsin. Office is next to two hospitals. Partnership is available after one year. Send CV to Dept 613 in care of the Journal. p4-9/88

Wisconsin. OB/GYN (BC/BE) needed to join dynamic HMO-based multispecialty group practice. University town of 55,000 near Minneapolis. Community and recreation outstanding. Competitive salary and fringes. We take pride in our patient care. Contact Robert A. Braastad, MD, Group Health Cooperative, 1030 Regis Court, Eau Claire, WI 54701; ph 715-836-8552. p5/88;6-9/88

West Bend, Wisconsin, General Clinic, a 20-physician multispecialty group is seeking additional B/C, B/E physicians in **Family Practice, Pediatrics, OB/GYN, Internal Medicine, Urology, Dermatology,** and **ENT.** First-year salary and benefits guaranteed. Corporate association after one year. Located in a family-oriented, economically strong small city surrounded by four-season recreational and scenic Kettle Moraine area 30 miles north of metropolitan Milwaukee. Contact Hans W Schmelzling, Administrator, 279 S 17th Ave, West Bend, WI 53095; ph 414/338-1123. 7tfn/87

Family Practitioner to join a progressive 12-physician practice at its Ellsworth, Wisconsin branch. Rural community 40 miles from St Paul, Minn. Liberal benefit package. Salary commensurate with background and experience. Contact R.M. Hammer, MD, River Falls, WI 54022; ph (715) 425-6701 or (612) 436-8809. 7tfn/88

Physicians to take in-house call. Ideal position for residents and moonlighting physicians. Second-year residents may be suitable. Call Donna, (815) 395-5187 or write ETC, Ltd, PO Box 8034, Rockford, IL 61125. 6-8/88

Emergency Medicine, Otolaryngologist, Urologist, and Obstetrician/Gynecologist to join multispecialty group practice in Woodruff, WI. Guaranteed annual income and excellent fringe benefit program. Send CV to R J Sloan, MD, Lakeland Medical Associates, Ltd, PO Box 549, Woodruff, WI 54568. 4tfn/88

PHYSICIANS EXCHANGE

continued

Baraboo, Wisconsin. Emergency Department at St Clare Hospital seeks full and part-time physicians. Eight thousand annual visits. Hourly compensation. Pleasant area in which to live, near Devil's Lake and the Baraboo Hills. Also, Madison nearby. Contact: Mr Ronald Levy, President, St Clare Hospital, 707 14th St, Baraboo, WI 53913, ph 608/356-5561. 6-8/88

Emergency Medicine, Brainerd, Minnesota. Need BC/BE EM or FP. Join a BC/EM MD and 18 MD multispecialty clinic. Two hours from Minneapolis. Beautiful lakes and trees, ideal for families. Call collect/write Curtis J. Nielsen (218) 829-0354 or 4901. PO Box 524, Brainerd, MN 56401. 6-8/88

Family Practice partnership, Chilton, Wis, (near Sheboygan, Appleton, Fond du Lac). Ultra-modern and urban-designated hospital. Rapidly expanding practice with limited call schedule. Merely ask for informational mailing by contacting Joe Schumacher. Write Calumet Medical Center, Chilton, WI 53014; ph (414) 849-2386. p6-8/88

BC/BE General Internist to join 26-MD multispecialty group with four internists, one nephrologist and one gastroenterologist. Top salary first year, full incentive thereafter. Central Wisconsin university town with drawing area of 80,000. Send CV to Dr John Gauder, Rice Clinic, SC, 2501 Main St, Stevens Point, WI 54481, or call collect 715/344-4120. 12tfn/87

Twenty-nine physician multispecialty clinic located in desirable East Central Wisconsin location is seeking Board-certified or Board-qualified orthopedic surgeon to round out its services. Lab, x-ray, excellent hospital. Liberal guarantee and benefits. If interested contact D F Sweet, MD, Fond du Lac Clinic, SC, 80 Sheboygan St, Fond du Lac, WI 54935. 9tfn/87

The Wausau Medical Center is seeking BE/BC individuals in the following specialties: Cardiology, Dermatology, Family Practice, Infectious Disease, Obstetrics/Gynecology, Pediatrics and Rheumatology. Modern clinic facility located across the street from modern 300-bed hospital. Full partnership in three years. Easy access to lakes, woods and mountains. Write including CV to D K Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, WI 54401. p4tfn/88

General Surgeon and **Family Practice** opportunities in a group setting. Located in a family-oriented economically strong small city. Located near lakes and metro area of Green Bay and Appleton, Wis. Send CV to Andrew Lagatta, President, Clintonville Community Hospital, 35 N Anne St, Clintonville, WI 54929. 6-10/88

BC/BE Family Practice to join six-BEFP and one BC general surgeon in scenic northern Wisconsin. Outstanding recreational area. New clinic facility attached to hospital. First year salary with production incentive. Please send CV/contact Paul Goellner, MD, Northwest Medical Center, 707 Ash Street, Spooner, WI 54801; ph (715) 635-2151. p6;7-8/88

Internist with or without subspecialty interests. Board-certified or eligible to join a well-established nine man expanding multispecialty group. Location is in a southeastern Wisconsin city of 36,000 with access to a large inland lake, initial salary plus percentage as an associate. Full status in-service corporation with shared overhead and an incentive orientated formula after the first year. Please contact E.T. Ayala, MD, Department of Internal Medicine, Sharpe Clinic, SC, 92 East Division St, Fond du Lac, WI 54935; ph (414) 921-0560, collect. p6-11/88

Wisconsin, Northeastern. BC/BE Family Practice physician to join our multispecialty growing clinic in Appleton, Wisconsin. OB is optional. Guaranteed salary during the first year and an excellent benefit package with paid malpractice. The geographic region served includes the Fox River Valley, which is located in northeastern Wisconsin, and is a moderately populous, semi-urban area which prides itself on a high quality of life. Numerous outdoor recreational opportunities are readily available while two major universities, several small colleges, and active civic organizations provide cultural and educational opportunities for physicians and their families. For more information, please send your curriculum vitae or call Mr Art Schuetze, Administrator, Medical Arts Clinic, 1501 S. Madison St, Appleton, WI 54915; ph 414-730-4425. 5-7/88

Family Practice, Pediatrics, and Internal Medicine—Park Crest Medical Clinic in suburban Milwaukee has immediate openings in these three specialties. For more information, please contact Sherry VanErt, 2665 S Moorland Rd, New Berlin WI 53151: ph 414/786-1199. p4-7/88

Eagle River—Great opportunity for two BC/BE family practice physicians to join well-established practice. Guaranteed annual income and future partnership available. For more information, send resume to Judy Harris, Recruiter, UW Office of Rural Health, 810 University Bay Dr, Madison, WI 53705 or call collect 608/263-7933. 1tfn/88

North Dakota. Thirty-five physician multispecialty group seeking orthopedic surgeon, unlimited potential, desirable medium size community in large service area. Position carries exceptional first-year income and benefit package. Contact Robert Suleski, 250 Regency Court, Waukesha, WI 53186; 1 (800) 338-7107 or (414) 785-6500 (collect in Wisconsin). 7/88

Family Practice, Brainerd, Minnesota. Immediate opening for seventh BC/BE FP for 18 multispecialty clinic. No capitation. Two hours from Minneapolis. Beautiful lakes and trees, ideal for families. Call collect/write Curtis J. Nielsen, (218) 829-0354 or 4901. PO Box 524, Brainerd, MN 56401. 6-8/88

Family practice. Thirty-four physician multispecialty group conveniently located between Chicago and Milwaukee. Well-equipped clinic offering salary guarantee with incentive bonus; excellent fringe benefits and early ownership. Please send current curriculum vitae to Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 4tfn/88

NEW PHYSICIANS FOR WISCONSIN
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UW Office of Rural Health
810 University Bay Drive
Madison, WI 53705
608/263-7933
7-12/88;1-6/89

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(Student Health Clinic)
Vermillion, South Dakota

Responsibilities include providing patient care, medical leadership, and direct supervision of medical personnel including nurse practitioner and physician assistant. University School of Medicine appointment eligibility. Prefer internist, pediatrician or family practitioner with demonstrated interest/training in adolescent and preventive medicine. Salary is competitive with excellent fringe benefits including professional liability. This is an academic year appointment.

Send application and resume with names, addresses, and telephone numbers of three references to: Dr William Donohue, Vice President For Student Life, Room 205 Slagle Hall, 414 East Clark, Vermillion, SD 57069. 6-7/88

PHYSICIANS EXCHANGE

continued

Family Practice physicians. BC/BE, two positions available. Two-man group and solo practitioner each seeking additional physician for rapidly expanding practices. Located in southern Florida near Ft Lauderdale. Excellent opportunities with partnership potential after first year. Negotiable salary with incentives, liberal benefit package. Please send CV to Virginia K. Norquist, Nu-Med Hospitals, 16633 Ventura Blvd, 13th Floor, Encino, CA 91436. p6-7/88

MEDICAL FACILITIES

Kenosha, Wisconsin. Superb opportunity to purchase established and lucrative independent dermatology practice. Office management, staff, and billing services included. Above average initial guarantee. Contact Rebecca Turley, Executive Consultant, 250 Regency Court, Waukesha, Wis 53186; ph (414) 785-6500 (collect). 7/88

Wanted to purchase: Established pediatric practice in Milwaukee. Days: (414) 771-0500; evenings: (414) 781-1497. 7-9/88

For Sale. IBM computer AT 512K, IBM enhanced color display and enhanced graphics adapters, $5,500. Santiago Medical Manager with six months of remaining support, $2,500. IBM "Doctors Office Manager," $500. C.ITOH printer, C-310 dot matrix and business printer with letter quality capability. 300 cps draft proportioned mode 62 cps near letter quality. For more information, please call (715) 479-2397, Tuesdays and Thursdays, 8:00 am to 4:30 pm. 7-8/88

MISCELLANEOUS

HOLTER MONITOR

Quality Scanning for reel or cassette type recorders by qualified technicians and certified cardiologists' interpretations, scan price $35.00 with UPS speedy delivery. Recorders loaned, leased, or purchase new dual-channel Holter recorders, $750.00, with two-year warranty. For more information call Advance Medical and Research Center 1-800/552-6753. 11tfn/85

REAL ESTATE

Secluded NW Wisconsin retreat. Forty acres, 550' frontage on uninhabited 30 acre lake. Beautiful six sided, two story, three bedroom, full basement, custom modern home. Complete privacy, wildlife, and large pines. For more information write or call Buck McMinn, Box 296, Chelan, WA 98816; ph 509-682-5204. n/c

MEDICAL MEETINGS—CONTINUING MEDICAL EDUCATION

WISCONSIN

JULY 29-31, 1988: Wisconsin Dermatological American Club, Kohler. 12tfn/87

AUGUST 3-8, 1988: *"International Doctors In Alcoholics Anonymous,* Stouffer Hotel, Baltimore, MD. Info: Information Secretary, IDAA, 1950 Volney Rd, Youngstown, OH 44511; ph 216/782-6216. g1-7/88

SEPT 9-11, 1988: Wisconsin Society of Anesthesiologists, Convention Center/Embassy Suites, Green Bay. g10tfn/87

SEPTEMBER 29-30, 1988: *Advanced Trauma Life Support (ATLS) Provider Course,* at Gundersen Clinic/Lutheran Hospital, La Crosse, Wis. Info: Thomas H. Cogbill, MD, 1836 South Ave, La Crosse, WI 54601. 7-8/88

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 50¢ per word, with a minimum charge of $20.00 per listing. *All listings must be prepaid.*

BOXED LISTINGS: $25.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 15th of the month preceding the month of publication; *eg,* copy for the August issue is due by July 15. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 1-800-362-9080.

FOR LISTING of other meetings see the January 1, 1988 issue of the *Journal of the American Medical Association:* Continuing Education Opportunities for Physicians for period March 1988 through August 1988.

OCTOBER 1, 1988: *Wisconsin Society of Radiation Oncologists,* Concourse Hotel, Madison. 4tfn/88

OCTOBER 3-7, 1988: 54th Annual Scientific Assembly of the American College of Chest Physicians, Anaheim Convention Center, Anaheim, Calif. Info: Division of Education, American College of Chest Physicians, 911 Busse Highway, Park Ridge, IL 60068; ph 312-698-2200. g5-8/88

OCTOBER 20-21, 1988: Wisconsin Chapter, American College of Emergency Physicians, The Abbey, Lake Geneva. 2tfn/88

NOVEMBER 4, 1988: *Wisconsin Orthopaedic Society,* Olympia Resort, Oconomowoc. 4tfn/88

NOVEMBER 5, 1988: Wisconsin Allergy Society, InnTowner Hotel, Madison. Info: Robert Bush, MD, 2500 Overlook Terr, Madison, WI 53705; ph (608) 256-1909. gtfn/88

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State Medical Society of Wisconsin

Dates and locations of ANNUAL MEETINGS 1989-1993

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel, unless otherwise indicated.

1989—April 13-15
1990—April 26-28: *Green Bay*
Convention Center, Embassy Suites
1991—April 18-20
1992—April 23-25
1993—April 15-17: *La Crosse*
Convention Center, Radisson

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

AMA

DECEMBER 4-7, 1988: Interim House of Delegates, Dallas, TX.

JUNE 18-22, 1989: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 3-6, 1989: Interim House of Delegates, Honolulu, HI.

JUNE 24-28, 1990: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 2-5, 1990: Interim House of Delegates, Orlando, FL.■

Wisconsin Specialty Society Meetings 1988

- Wisconsin Society of Obstetrics and Gynecology, July 21-23, 1988, Landmark Resort, Egg Harbor.
- Wisconsin Society of Anesthesiologists, Sept 9-11, 1988, Convention Center/Embassy Suites, Green Bay.
- Wisconsin Society of Internal Medicine, Sept 15-17, 1988, Milwaukee Marriott.
- Wisconsin Radiological Society, Sept 30-Oct 1, 1988, Concourse Hotel, Madison.
- Wisconsin Allergy Society, Nov 5, 1988, InnTowner Hotel, Madison. 6tfn/88

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ANNOUNCEMENTS

LEUKEMIA GROUP SEEKS GRANT APPLICATIONS

The Leukemia Society of America is accepting applications for 1989 grants in basic science and clinical level research of leukemia and related diseases.

Three awards are being offered: Scholar grants totaling $200,000 for five years to researchers with five years or more experience who have demonstrated their ability to conduct original investigations; Special Fellow grants totaling $87,000 for three years for researchers in the intermediate stages of career development; and Fellow grants of $70,500 for three years for promising investigators with minimum or no prior experience.

A PhD, MD, or equivalent degree is required of all candidates.

Awards are not given to individuals who are receiving full institutional salary support.

The deadline for applications is September 1, 1988. Only one application in each grant category may be submitted from each faculty sponsor. Proposals of all categories of grants will be evaluated on a competitive basis by the Leukemia Society's Grant Review Subcommittee in late January 1989. Applicants should use only the most current forms to apply for grants.

Funding for all grantees begins on July 1, 1989.

For application forms and additional information, write to: Research Grant Coordinator, Leukemia Society of America, 733 Third Ave, New York, NY 10017.

Joint Commission Schedules 1988 Teleconferences

The Joint Commission on Accreditation of Healthcare Organizations will present three teleconferences in 1988 as part of a continuing agreement with the Hospital Satellite Network (HSN). Each live two-hour, interactive teleconference offers insights into key areas of the Joint Commission's accreditation requirement. Broadcast schedule is:

Sept 1: "Medical Staff Quality Monitoring: Keys to Success,"

Oct 7: "Assuring the Quality of Ambulatory and Managed Health Care Services."

Teleconferences will each begin at 1:00 pm, Eastern time, and will be moderated by William Jessee, MD, vice president for education at the Joint Commission. To register for the teleconferences, call the Joint Commission's customer service unit at 312-642-6060, extension 650. g5tfn/88

BOOKS RECEIVED

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, William S Middleton Memorial Medical Library, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

Neurology: Problems in Primary Care, by James L. Bernat, MD, and Frederick M. Vincent, MD. 1988. Medical Economics Books, Box C-779, Pratt Station, Brooklyn, NY 11205-9066. Pp 656. Price: $39.95.

Management of Common Problems in Obstetrics & Gynecology, edited by Daniel R. Mishell Jr, MD, and Paul F. Brenner, MD. 1988. Medical Economics Books, 680 Kinderkamack Rd, Oradell, NJ 07649. Pp 699. Price: $42.95.

I Can Cope: Staying Healthy with Cancer, by Judi Johnson and Linda Klein. 1988. DCI Publishing, 13911 Ridgedale Dr, Minnetonka, MN 55343. Pp 216. Price: $8.95.■

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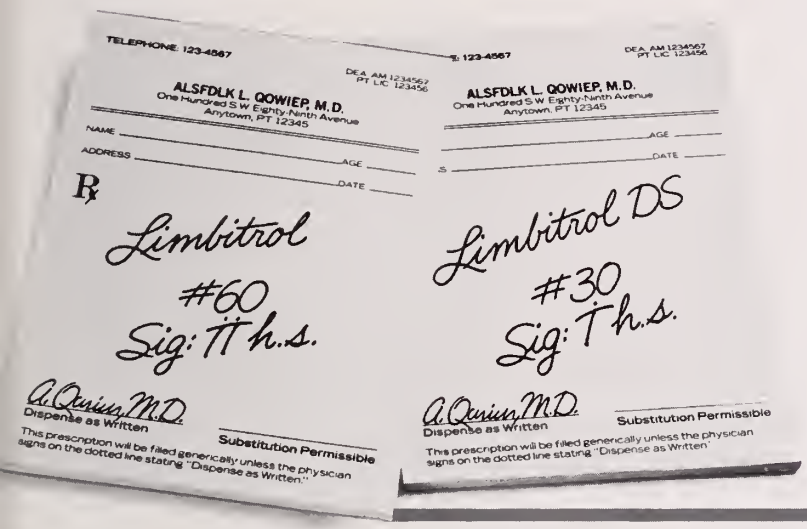

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References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Feighner VP, *et al: Psychopharmacology 61:*217-225, Mar 22, 1979.

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Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.**

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. *Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. *Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. *Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. *Endocrine:* Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

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- First-week reduction in somatic symptoms[1]

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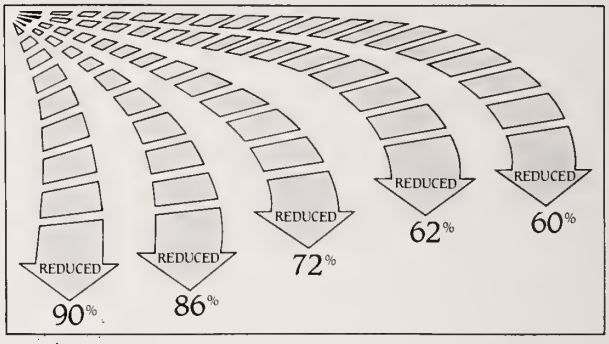

*Patients often presented with more than one somatic symptom.

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Official Publication of the State Medical Society of Wisconsin

Wisconsin Medical Journal

1988 Membership Directory

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WISCONSIN MEDICAL JOURNAL

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WISCONSIN MEDICAL JOURNAL (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the editorial board, subject to policy direction of the Society's Board of Directors. The managing editor is responsible for overseeing the production, business operation, and contents of the Journal. The editorial director is responsible for editorials. Unsigned editorials express views consistent with the policies of the State Medical Society of Wisconsin. Signed editorials express personal views of the author for which the Society takes no responsibility. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus," "Hospital Literature Index," and "Cambridge Scientific Abstracts."

Vol. 87 No. 8

STATE MEDICAL SOCIETY OF WISCONSIN

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THE STATE MEDICAL SOCIETY OF WISCONSIN, created by the Territorial Legislature in 1841, represents nearly 7000 member physicians in Wisconsin, comprising 55 county medical societies and 28 medical specialty sections. The purpose of the Society is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society include continuing medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, services for physicians, operation of a Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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Secretary's report

A new approach to impaired physicians

In recent months the public's attention has once again been drawn to the problem of impaired physicians. The state Department of Regulation and Licensing has proposed a streamlined program and the State Medical Society House of Delegates has taken steps to greatly expand SMS activities in this area.

The initial challenge was taken up in 1977 by the members of the SMS Commission on Mediation and Professional Ethics, then chaired by Dr Gerald C. Kempthorne, when a program was created to "serve the need for compassionate assistance for Wisconsin physicians whose personal and professional performance is jeopardized through abuse of alcohol or other chemical substances, emotional illness or senility."

How it works

Anyone may contact the SMS to express concern that a physician may be suffering an impairment. Confidentiality is assured. Most reports are received from fellow physicians, hospital administrators, county medical society officers, clinic officers, family members and patients. The SMS staff is responsible for accepting reports and carefully gathering relevant information from responsible sources. The Managing Committee monitors this process closely.

If the committee is satisfied that the evidence supports the likelihood of an impairment, the chairman chooses a team of no less than two intervenors, based on the nature of the suspected impairment. Intervention may result in one of the following: a recommendation for inpatient treatment at a qualified facility; a recommendation for an inpatient or outpatient evaluation to clarify existing concerns about impairment; a recommendation that the physician appear before the Managing Committee for consultation; or a recommendation for other, more appropriate, courses of action.

Not all initial interventions are successful. If the physician expresses denial, or refuses to cooperate with recommendations, the Managing Committee may recruit new volunteers for a second intervention. Three separate interventions are not common, but may be authorized. If the subsequent interventions fail, the Managing Committee may refer the physician to the jurisdiction of the Coordinating Council on Physician Impairment. If the intervention is successful, the committee monitors the physician for not less than two years.

Thomas L. Adams

The Coordinating Council on Physician Impairment was created in 1980 in a unique agreement between the SMS and the Medical Examining Board. The council was formed to guide the Society's program and ensure that appropriate information is shared so that proper action can be taken if a physician refuses to enter, or fails to respond, to rehabilitation. Since 1980, about a half dozen physicians have been referred to the council.

* * *

The program has provided direct assistance to more than 60 physicians who have completed inpatient and outpatient treatments, follow-ups, and who have—I am happy to report—recovered. During the past 11 years, the SMS program has grown

Impaired physician

Persons interested in the Impaired Physician Program may call 608-257-6781, or toll-free in Wisconsin 1-800-362-9080, to explain their concern to John LaBissoniere, Sally Wencel or H.B. Maroney of the SMS staff. The caller's identity will be kept in complete confidence.

in experience and maturity while gaining momentum as it evolved.

The Society's commitment to provide assistance to its own was underscored when in 1982 the program was expanded to include a six-member managing committee and renamed the Statewide Impaired Physician Program. The House of Delegates of the Society has now reaffirmed that commitment by approving a $15 dues increase in 1989 to fund expansion of the program and retain a half-time consultant to serve as medical director to the Managing Committee.

The new approach is more comprehensive and proactive—emphasizing education and prevention, community identification of impaired physicians, and involvement of family members and non-physician health care professionals. And a Physician Benevolent Assistance Fund, created by charitable donations, helps impaired physicians who are unable to pay the costs of inpatient treatment.■

Editorials

Medicare and nonparticipating physicians

MANY NONPARTICIPATING physicians nationwide (including myself) have received letters from Medicare Part B. The letters begin by stating that a "nonparticipating physician who provides services, on an ongoing basis, which are determined to be not covered because they are not reasonable and necessary for the treatment of illness and injury or to improve the functioning of a malformed body member is not permitted to bill the beneficiary of these services." Further, if the physician collects any amount for such noncovered services, he or she is required to refund this amount to the beneficiary.

A refund, however, is not required if: "The physician did not know and could not reasonably have been expected to know that the services would be found to be not reasonable and necessary." How in heaven's name does any physician know what Medicare is going to cover?

In my situation, the patient was referred in writing from a medical center where he had had extensive surgery. My charge for this visit was $19. Incidentally, the amount has never been paid by the patient either.

The letter went on to state that if I had collected any amount from the patient as full or partial payment for the services specified above, I must refund these amounts to the beneficiary within 30 days or request a review of the decision. "A physician who fails to make a required refund within the 30-day period may be subjected to civil money penalties of not more than $2,000 for each service and/or exclusion from the Medicare program." (The latter may be considered a blessing by a number of frustrated physicians.) Further, the physician may also be subject to an assessment of not more than twice the amount claimed for each service in lieu of damages. The patient, who has been wintering in the south, will be notified that his unpaid bill need nor be paid. At least I was not threatened with incarceration, although I understand some of the federal country clubs are quite comfortable and have many influential and interesting members.

—*Victor S. Falk, MD*
Edgerton■

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RBRVS: Ensuring fairness requires a united front

IN LATE SEPTEMBER, the long-awaited report on the Harvard resource-based relative value scale (RBRVS) will be submitted by Harvard to the Health Care Financing Administration (HCFA). During the ensuing six to nine months, the AMA, Harvard, Otis Bowen, MD, of Health Services, and the Physician Payment Review Commission (PPRC) will be reviewing this document.

During this time, the state medical associations and specialty groups will also be reviewing this study and reporting their reactions to the AMA. The SMS will keep its members informed of the progress of these studies. It will also form a special task force to address the Harvard study. The AMA will, I hope, have a response to the study by its December interim meeting in Dallas.

Apprehension about this study is rife among physicians today. We all wonder how it will affect us in our individual practice. Primary physicians hope they will be paid more. Surgeons and specialists fear they will be paid less. Those with high premiums for malpractice hope that their financial worries will be taken into account. And all hope that the increasing costs of running a practice will be factored into the equation for reimbursement. It is hoped that, when all is said and done, this long-awaited study will address itself to all our concerns. The study gives promise of equity for all of us and is preferable to other forms of reimbursement, such as physician DRGs or national capitation schemes.

While the report will soon be with us, its implementation will not. Informed sources do not think that implementation of the relative value system will take place until 1990. During this interim, it is vital that we work in harmony with the SMS, specialty groups and AMA. It is important that we present a unified voice to Congress, HCFA and the PPRC.

As information about the study becomes available to you, communicate your reactions to the SMS—they will be gratefully received and will help the SMS in its response to AMA, which will collate such responses from across the country. Through such activity, the physicians of this state may get equitable treatment for their services and be relieved of what has been a justified concern for so many years.

—John P. Mullooly, MD
Milwaukee■

Peer review and the Patrick case

SOME OF THE UNCERTAINTY with regard to the impact of the May 1988 Supreme Court ruling in the Patrick case has been cleared with the understanding that good faith peer review remains protected under state and federal law (*Medigram* Vol 11, No. 11 and page 12 of this *WMJ* issue).

But the damage has been done.

In the past few years it has become harder and harder to get physicians to participate in peer review—a process in which they really cannot win and have much to lose. Now, all they have to do if they want to turn down the job is cite the Patrick case as an excuse.

Even hospital credentials committees, usually made up of people who have a strong sense of duty and who recognize the necessity for peer review, really will be hamstrung because of the increasing difficulty in keeping marginal candidates off the hospital staff, to say nothing of the virtual impossibility of removing people from the staff once they've been accepted.

From now on, physicians asked by the credentials committee to write letters with regard to candidates' qualifications are unlikely to be entirely truthful in writing if they believe the applicants to be poor prospects, and they surely won't stand behind their own negative verbal statements when confronted by the spurned applicants in the course of the appeal process. Who, in their right mind, is going to stand up to the threat of a suit which can amount to six or seven figures?

Unless a guarantee of protection for peer reviews is forthcoming, meaningful peer review will cease to exist.

—Wayne J. Boulanger, MD
Milwaukee■

Opinion policy

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Soundings

The rescuer

David L. Schiedermayer, MD
Milwaukee

THE MOUNTAINSIDE was very steep and treacherous near the precipice. Several rescuers had gone up trying to get a woman who was trapped against a small outcropping of rocks. The woman was difficult to reach even with the use of fairly advanced rescue equipment, and it would require risking a rescuer's life to get to her.

That is what he did. Inching along the edge of the cliff, working for each finger and toehold, he made his way toward her. His muscles were strained to the limit, for any misstep could mean severe injury or death for him. When his hands reached hers, he felt the flood of joy within him for he had been able to rescue a fellow human being. He connected the rope to her, and together they were pulled to safety. She recovered, but she never thanked her rescuer.

An 18-year-old man was brought into the hospital, severely injured by a shotgun blast to his upper mandible; a 21-year-old woman was brought into the hospital emergency room on the same night, having taken an overdose of drugs; and they were attended by the same physician. He knew he would be up all night. He would have the responsibility for stabilizing them and getting them appropriate treatment, but he remembered the other suicidal patients he had treated and what had happened when they improved. They were often unthankful.

As someone who felt that life had great value, this physician had difficulty understanding why someone would want to put themself to death. He couldn't see why they smoked or drank enough to cause diseases, or ate themselves into obesity, or didn't take their blood pressure medication. He had difficulty dealing with the thought that there are those who wanted to die by their own hands. When he had finally been able to rescue them, they were unthankful—even angry. It was true that he had thwarted their plans, but were their plans to be respected? And wouldn't they change their plans later, given the chance and the counseling?

He had seen patients who had tried suicide in multiple ways. One woman had taken an overdose of drugs and jumped off a bridge in an attempt to ensure completion of the deed, but she had only broken her femurs and crushed her vertebrae. Others had multiple cuts on their wrists from previous attempts, but they now were trying with drugs.

Their reactions to his treatments were predictable. He would pump their stomachs, clearing out remaining pill fragments. He would put activated charcoal down the tube, using its absorbent action to wipe up the remains of any toxic agents in the intestines. He would draw drug levels of all known drugs and follow those levels every few hours to see whether they were still rising and more drug was being absorbed. He would monitor their hearts for toxic effects like arrhythmias, observe their respiratory rates very carefully, and intubate them if they became unconscious, needed airway protection, or developed shallow breathing. He would treat with a specific antidote, if one was available. He would wait. Perhaps in several hours, perhaps in a day or two, the patients would wake up. They would be bewildered at having survived the attempt, especially if it was a serious one, and they would be angry with him for having stood in the way. Some patients would sign out against medical advice the minute they woke up (if they were admitted without a police hold). Other patients would pull out their tubes, Foley catheters, and intravenous needles, and try to escape from the intensive care unit.

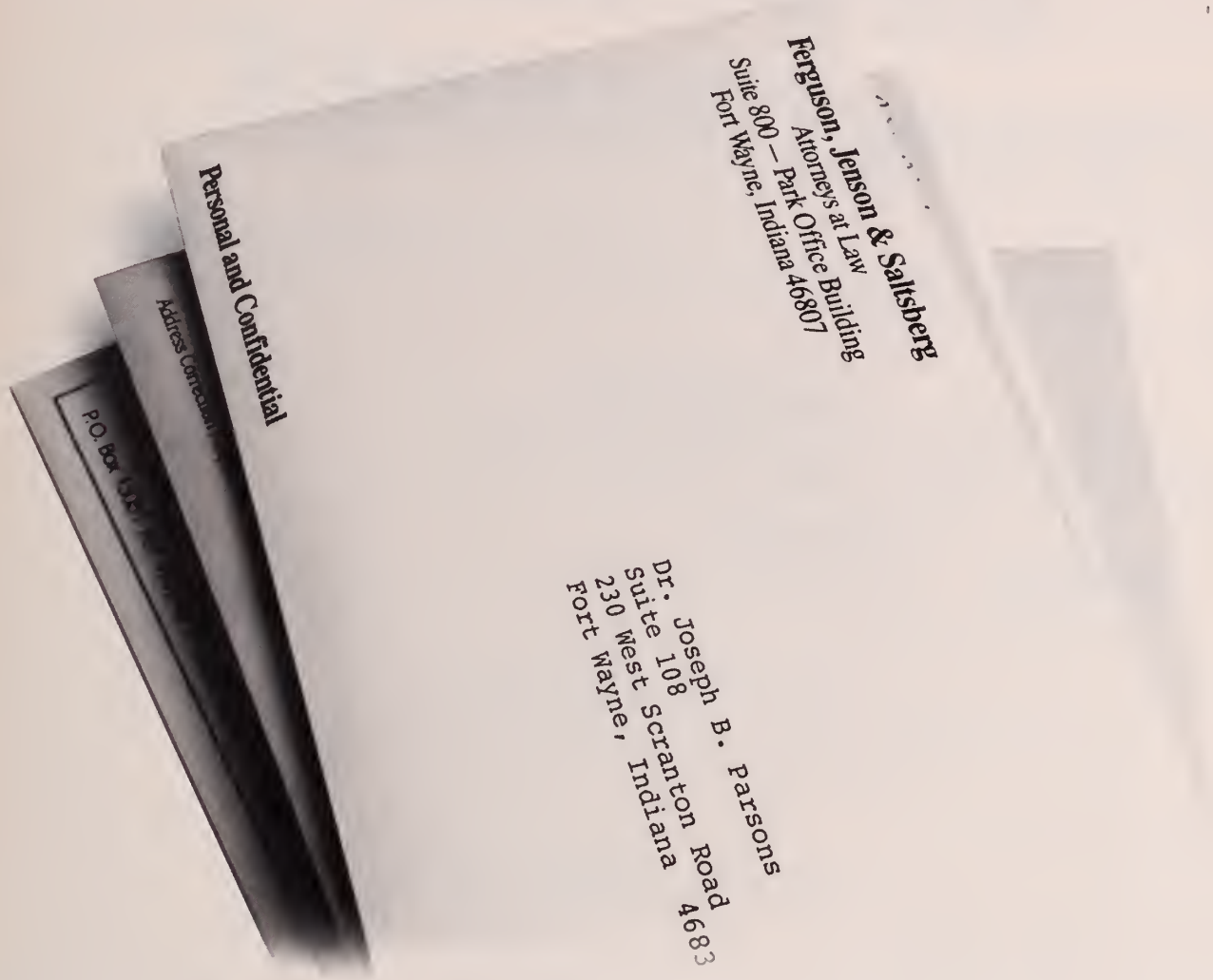
It occurred to him one day that he was merely doing what rescuers do on the mountain. These patients, for whatever reason, had also fallen into the precipice. Later, they might not object to being rescued, and they might make something very useful of their lives. But for the time being, lying there panting and exhausted in the crack, they just wanted to be left alone. They felt quiet and peaceful, death gently sliding over them, and they were angry at the interruption.

One thing that he could not expect from them was thanks. This was just not going to be a word in most of their vocabularies.

It was becoming more and more a part of his job. He recalled the statistics he had read about a small, peaceful, suburban school not far away. Seven percent of the students surveyed said they had attempted suicide. Sighing, he reached for the endotrachial tube. It was going to be another long night.■

Dr Schiedermayer is assistant professor, Division of General Internal Medicine, and associate director, Center for the Study of Bioethics, Medical College of Wisconsin, Milwaukee. Reprint requests to: David L. Schiedermayer, MD, Center for the Study of Bioethics, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, WI 53226 (phone 414-257-6040). Copyright 1988 by the State Medical Society of Wisconsin. This piece is based on a true story from a ski patrol rescuer and on actual accounts of patient care.

Crisis in black and white.



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The telephone

Richard G. Roberts, MD, JD
Madison

Future anthropologists will likely determine that 1876 was the year in which humans first showed signs of what could become a new appendage: a telephone permanently affixed to the auricle. While some of the species have struggled to resist this growth—cellular and portable phone dealers have been disappointed with sales to physicians—the mutation appears inevitable.

Physicians spend up to 20% of their professional time on the telephone. No other element in a physician's life is as intrusive, no other causes so much lost sleep—except, perhaps, a malpractice suit. The telephone and malpractice litigation, when combined, become every doctor's worst nightmare. This article offers suggestions on using the telephone so as to minimize the risk of a malpractice claim.

Rapport. The telephone offers another opportunity to nurture good relationships with patients. A post-discharge call shortly after hospitalization speaks volumes to the patient—even when it comes from a surrogate (nurse, receptionist, etc). The telephone can be the next best thing if the physician is not able to be with the patient.

Refills. Physicians are frequently asked to refill prescriptions over the phone. Many offices develop useful protocols for dealing with refills: "Please give us as much notice as possible of your prescription refill needs," or "The doctor calls in refills at the end of each morning and afternoon."

Never authorize a refill without the patient's medical record available. Document the pharmacy, medication, dosage, directions, amount dispensed, and number of refills authorized, eg: Real Inexpensive Pharmacy, HCTZ 25 mg Q day, #60, may refill × 3.

Results. No diagnostic test results should get into a patient's chart without the doctor's initial or signature. This ensures that the physician has seen each report and minimizes the risk of an abnormality going unpursued because the doctor was unaware.

Similarly, a note should be placed in the chart whenever results are communicated to the patient, along with the advice given. For example: "Called Pt. about high cholesterol—asked him to return in two weeks to discuss low-fat diet." Before the patient leaves the office, be certain that you are both clear on who will do

the calling for results (you, your staff, or the patient) and when the result will likely be available.

Recommendations. The extent to which the physician will be liable for telephone advice depends on the extent to which the patient relied on the physician's advice. Physicians have been successfully sued for offering medical advice over the telephone to patients they have neither seen nor billed. For example, a California physician paid a six-figure award to a young man who called to complain of chest pain. The doctor had never seen the patient, nor did he charge him for the telephone consultation. The man successfully argued that he had relied on the physician's advice and suffered because that advice delayed the ultimate diagnosis of his myocardial infarct.

Telephone conversations involving patient care issues (even when speaking to relatives of the patient) should be documented with the date, time, caller, and the substance of the discussion and recommendations. For example: "9/2/99, 10:30 AM, called

Dr Roberts is assistant professor in the Department of Family Medicine and Practice at the University of Wisconsin Medical School. He is also vice chairman of the SMS Medical Liability Committee. Copyright 1988 by the State Medical Society of Wisconsin.

patient's daughter to discuss no-code status." Many physicians carry preprinted telephone note pads or a tape recorder to facilitate the documentation of all patient care calls, whether they occur in the office or out.

The telephone has become a professional lifeline for the practice of medicine. Physicians should regard the phone as an important piece of medical equipment: it possesses the same ability to help as to harm. If a physician is uncomfortable providing advice to the caller—there is no prior relationship, the history is inadequate, the problem is not amenable to telephone management, etc—then the doctor should insist that the patient be seen and examined.

The courts demand that a prudent physician offer medical advice only after obtaining sufficient information to arrive at a reasonable diagnosis, which often includes a "good faith" examination, so the substance of phone conversations should be documented by the physician.

Next time you're groping for the phone in the dark—bleary-eyed and half-dressed, growling, grumbling and trying to answer yet another late night call—please try to reflect on what the practice of medicine would be like without the telephone. And remember, it could be worse: You could be answering a videophone.■

SMS helps monitor health fraud

The Office of Consumer Protection at the Department of Justice has been concerned about the reported increase in health fraud in Wisconsin and recently created a task force to investigate the problem. SMS staff is cooperating with the Justice Department by requesting physician members to report any information they may have on health fraud.

If you know of patients who have used questionable treatments—such as cancer, arthritis or AIDS "cures" or special dietary supplements—or have relied on solicitations promising that a device is Medicare reimbursable only to find out later it is not, please call the SMS Communications Division at 1-800-362-9080 (toll free) or 608-257-6781. Or you may call the Office of Consumer Protection at 1-800-362-8189 or 608-266-1852.■

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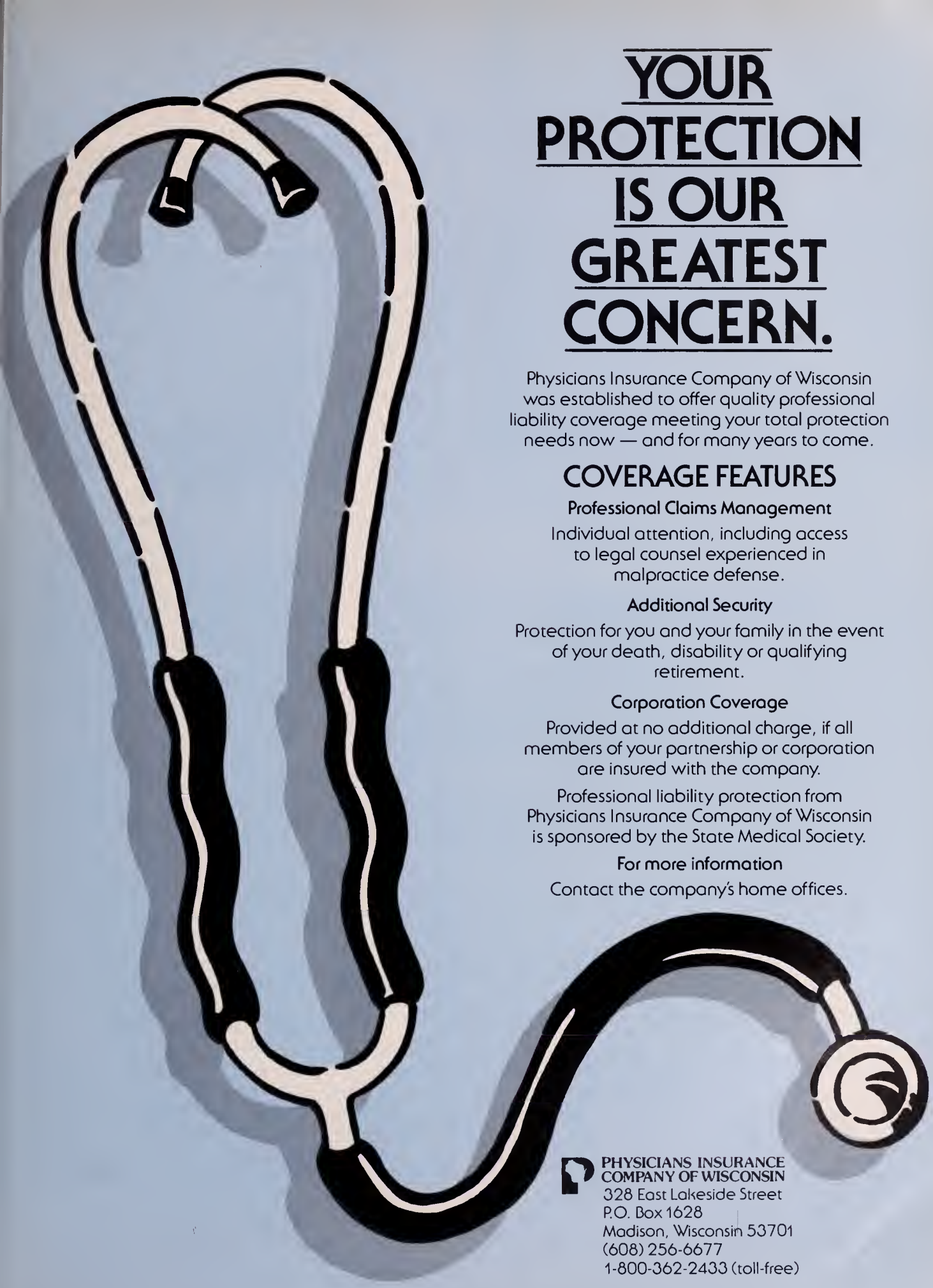

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Good faith peer review still protected

Although medical peer review apparently received a setback in May by the Supreme Court's ruling in the Patrick case, *good faith* review activities by physicians appear to be protected against antitrust suits.

The US Supreme Court ruled 8–0 (Justice Blackmun did not participate) in *Patrick v Burget* that peer reviewers in Oregon were not immune from federal antitrust liability under a "state action" defense because the state does not actively supervise peer review. Kirk Johnson, general counsel for the AMA, which had filed a friend of the court brief in the case, said, however, that there is no significant risk to physicians engaged in good faith peer review. He said the case was unique in that it was marked by a long history of personal conflict among the physicians and a peer review system the court found questionable. Johnson added that a 1986 federal law—the Health Care Quality Improvement Act—now greatly protects peer reviewers from such suits.

Writing for the court, Justice Thurgood Marshall said private parties could claim immunity from antitrust suits only when their anticompetitive acts were truly the product of state regulation, ie, the conduct must be clearly articulated and affirmatively expressed as state policy and it must be actively supervised by the state itself. The court held that in this case the second part of the test for immunity was not met. Justice Marshall specifically noted that although the HCQIA did not apply in this case because it arose before the law was passed, the HCQIA would immunize peer review actions if these actions were taken in the reasonable belief that they were in the furtherance of quality health care.

The case dates back to 1981 when the 11 physician defendants attempted to have the staff privileges of Timothy Patrick, MD, of Astoria, Ore., revoked for what they claimed was substandard patient care. Dr Patrick sued the physicians, charging that their actions were motivated by concerns over competition rather than the quality of patient care. The trial jury agreed with Dr Patrick and awarded him $650,000 in damages, which the federal district court raised to nearly $2.2 million. The US Court of Appeals for the 9th Circuit later reversed the decision, citing state action immunity.

The SMS believes that the Supreme Court, in the Patrick ruling, is saying that the peer review system is not above the antitrust law, but that physician reviewers who act in good faith—without malicious intent or for reasons of economic self-interest—are protected under state and federal law.■

Peer review shield law

Beginning in October 1989, physicians and health care facilities who have acted properly will be protected from private suits based on state antitrust law under the Health Care Quality Improvement Act (HCQIA). The act is already effective for actions under federal laws, and states may enact legislation to have the state provision apply earlier than the 1989 effective date.

To more fully protect themselves before the act is effective in Wisconsin, physician peer reviewers are advised to check the medical staff bylaws of their institutions and make sure the standards adhere to the HCQIA requirements.■

Key contact seminars

The SMS Division of Public Affairs will host two day-long Key Contact training seminars next fall. Scheduled for Nov 11 at the Olympia Village in Oconomowoc and Nov 12 at the Holiday Inn in Stevens Point, these seminars are aimed at improving participants' skills in interacting with state and federal lawmakers. Michael E. Dunn, a Washington-based political consultant and president of Dunn & Associates, Inc., will be the featured speaker. Dunn, most recently the keynote speaker at the WISPAC lunch during the SMS annual meeting, is known for his entertaining and dynamic presentations.

Seminar topics include: techniques for developing personal relationships with lawmakers, how to use community activities and other local ties as a bridge to elected officials, the role of legislative staff and how to hold a candidate fund raiser. Additional information on the seminars and registration materials will be available in the fall.■

Nursing home rates remain stable

According to the Wisconsin Annual Survey of Nursing Homes, the number of nursing home residents in Wisconsin rose by only 700 between 1980 and 1986, for a total of 49,200. During this time, the state placed a moratorium on nursing home construction and a cap on the number of nursing home beds (52,000).

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2. For the prevention of potassium depletion when the dietary intake is inadequate in the following conditions: Patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, and with certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS: Potassium supplements are contraindicated in patients with hyperkalemia since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: Chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene).

Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to enlarged left atrium.

All solid dosage forms of potassium chloride supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation.

WARNINGS: Hyperkalemia—In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic. The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction with Potassium Sparing Diuretics—Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene) since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions—Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage or perforation.

K-DUR tablets contain micro-crystalloids which disperse upon disintegration of the tablet. These micro-crystalloids are formulated to provide a controlled release of potassium chloride. The dispersibility of the micro-crystalloids and the controlled release of ions from them are intended to minimize the possibility of a high local concentration near the gastrointestinal mucosa and the ability of the KCl to cause stenosis or ulceration. Other means of accomplishing this (e.g., incorporation of potassium chloride into a wax matrix) have reduced the frequency of such lesions to less than one per 100,000 patient years (compared to 40–50 per 100,000 patient years with enteric-coated potassium chloride) but have not eliminated them. The frequency of GI lesions with K-DUR tablets is, at present, unknown. K-DUR tablets should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis—Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, potassium acetate, or potassium gluconate.

PRECAUTIONS: The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium. The treatment of potassium depletion, particularly in the presence of cardiac disease, renal disease, or acidosis requires careful attention to acid-base balance and appropriate monitoring of serum electrolytes, the electrocardiogram, and the clinical status of the patient.

Laboratory Tests: Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions: Potassium-sparing diuretics; see **WARNINGS.**

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C: Animal reproduction studies have not been conducted with K-DUR. It is also not known whether K-DUR can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. K-DUR should be given to a pregnant woman only if clearly needed.

Nursing Mothers: The normal potassium ion content of human milk is about 13 mEq per liter. Since oral potassium becomes part of the body potassium pool, so long as body potassium is not excessive, the contribution of potassium chloride supplementation should have little or no effect on the level in human milk.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: One of the most severe adverse effects is hyperkalemia (see **CONTRAINDICATIONS, WARNINGS,** and **OVERDOSAGE**). There have also been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see **CONTRAINDICATIONS** and **WARNINGS**); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE: The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see **CONTRAINDICATIONS** and **WARNINGS**). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration and characteristic electrocardiographic changes (peaking of T-waves, loss of P-waves, depression of S-T segment, and prolongation of the QT-interval). Late manifestations include muscle-paralysis and cardiovascular collapse from cardiac arrest.

Treatment measures for hyperkalemia include the following:

1. Elimination of foods and medications containing potassium and of potassium-sparing diuretics.
2. Intravenous administration of 300 to 500 ml/hr of 10% dextrose solution containing 10–20 units of insulin per 1,000 ml.
3. Correction of acidosis, if present, with intravenous sodium bicarbonate.
4. Use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia, it should be recalled that in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

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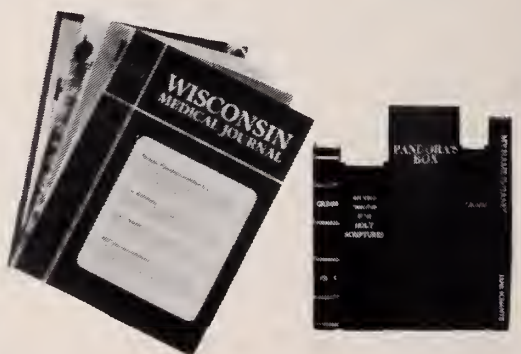

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Medicare: questions and answers

Q. What will Medicare do if I submit a diagnostic test—such as an x-ray, EKG or ultrasound—and do not add the statement "No Purchased Diagnostic Test" on my claim form?

A. Medicare will deny the service if this information isn't on the claim. You should resubmit a corrected claim to Medicare Inquiry Services and your claim will be reprocessed by the Claims Exam and Entry area. Your claim doesn't need to go through the review process.

Q. If I see a patient at the hospital who is under observation but isn't admitted, how should I submit a claim to Medicare for my services?

A. The services should be billed as an emergency room visit.

Q. I live in Marquette, if I see a patient in my office who lives in Michigan, which Medicare office should I send my claim to?

A. The Medicare office serving the area in which your office is located, WPS–Medicare has jurisdiction.

Q. To what department within Medicare should I send my MAAC request?

A. MAAC requests should be sent to the Freedom of Information Department. There is a charge for any MAAC request costing $15 or more to process.

Q. When my office staff calls Medicare for information about a claim we have submitted, they say they can not release information concerning the claim to anyone except the patient. Is this true?

A. If you do not accept assignment on the claim, Medicare cannot release any information concerning the claim to you unless: 1) the patient is in your office and approves the release of information to you, or 2) you have a written statement signed by the patient stating that Medicare can release this information to you.

Q. Medicare approves one nursing home visit a month. Does that mean per calendar month or every 30 days?

A. The guideline is applied according to calendar month.

Q. If I am billing for multiple surgical procedures should I reduce my fee for the second surgery?

A. Yes, you should reduce your fee for the second procedure by 50%. You should also use the 51 modifier on your claim so your reduced fee is not applied to your profile. Modified surgical procedures are exempt from the MAAC.

Q. Could you clarify the limitation on provider charges for concurrent anesthesia?

A. If you direct two or more CRNAs concurrently, (except in the case of cataract and iridectomy services) the number of base units recognized for those concurrent procedures is reduced as follows:

- Two concurrent procedures—10% reduction
- Three concurrent procedures—25% reduction
- Four concurrent procedures—40% reduction

Nonparticipating anesthesiologists must comply with their MAAC charges by reducing the base units by the appropriate percentage. For example, the MAAC conversion factor for Dr Smith is $20 per unit. Dr Smith medically directs two concurrent procedures so that the base units for each procedure are reduced by 10%. One of the procedures is assigned 5 base units and 2 time units. To determine the amount Dr Smith can charge for this procedure, the following calculation is used.

5.0 Base Units
− 0.5 10% reduction
= 4.5

4.5 Base Units (after reduction)
+ 2.0 Time Units
= 6.5

6.5 Total Units
× $ 20 MAAC conversion factor
= $130 MAAC charge

If any of the concurrent procedures are cataract or iridectomy cases, no reduction in the number of base units should be made. These surgeries, however, are counted in determining the total number of concurrent procedures. Similarly, although no reductions are applied to non-Medicare patients, those cases will also count toward the total number of concurrent procedures.

For example, Dr Smith supervises three CRNAs concurrently. Two of Dr Smith's patients, Jones and Thompson, are Medicare patients and the other, Larson, is a private pay patient. Jones has cataract surgery, Thompson has knee surgery and Larson has hip surgery. When Dr Smith submits a claim to Medicare for Thompson, the base units must be reduced by 25%, which indicates three concurrent procedures were performed.

Share the knowledge: If you have questions about Medicare that you would like to see answered in this column, send them to: Medicare Q&A, c/o Karen Lord, State Medical Society of Wisconsin, PO Box 1109, Madison, WI 53701.■

SHIP launched for uninsured workers

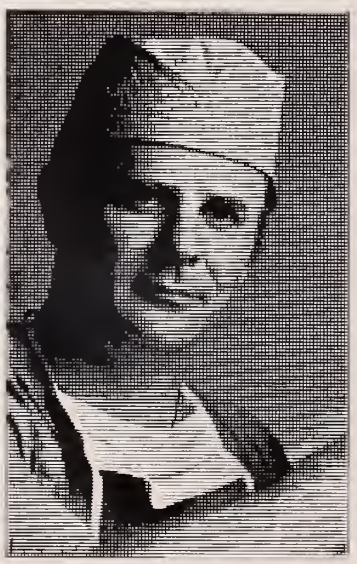
The State Health Insurance Plan (SHIP) pilot programs—aimed at addressing the growing number of uninsured workers in Wisconsin—has been signed into law by Gov Tommy Thompson after nearly seven years of study and discussion by various groups and agencies.

Part of a welfare reform package agreed to by the governor and the legislature, the SHIP plan contains three health insurance pilot programs for low-income workers. The first of these will provide a subsidy for low-income employees of businesses that do not provide health insurance for their workers. A second program is aimed at workers who may be offered a health insurance plan by their employers, but who cannot afford coverage for themselves or their families. The third plan would provide a Medicaid-style package for workers with disabilities.

The SHIP legislation also created a nine-member council—the Council on Pilot Programs for the Uninsured—to oversee implementation of the programs. To be made up of representatives of the governor, the Senate and the Assembly, the council will help the Wisconsin Department of Health and Social Services draft administrative rules on pilot sites, eligibility rules and program benefits. Under the legislature's timetable, these rules are to be complete by the end of the year.

Meanwhile, a Task Force for the Uninsured was created by the SMS at its annual meeting. Made up of physicians and representatives of businesses and elderly groups, the task force will study the problem from a non-governmental perspective. ■

HERE'S ONE DOCTOR WHO WON'T PAY HIS MALPRACTICE PREMIUMS THIS YEAR.



The Army covers that for him. As an Army Physician, there are a lot of worries associated with private practice that he won't have to contend with, such as excessive paperwork, and the overhead costs incurred in running a private practice.

What he will get is a highly challenging, highly rewarding experience. The Army offers varied assignments, chances to specialize, to further your education, and to work with a team of dedicated health care professionals, plus a generous benefits package.

If you're interested in practicing high-quality health care with a minimum of administrative burdens, examine Army Medicine. Talk to your local Army Medical Department Counselor for more information.

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- **Highly active *in vitro* against a broad range of gram-positive and gram-negative pathogens, including methicillin-resistant *Staphylococcus aureus* and *Pseudomonas aeruginosa****
- **For treatment of infections in the:**
  - **–lower respiratory tract†**
  - **–urinary tract†**
  - **–skin/skin structure†**
  - **–bones and joints†**
- **Convenient *B.I.D.* dosage – 250 mg, 500 mg and 750 mg tablets**

**In vitro* activity does not necessarily imply a correlation with *in vivo* results.

†**Due to susceptible strains of indicated pathogens. See indicated organisms in Brief Summary.**

CIPRO® SHOULD NOT BE USED IN CHILDREN OR PREGNANT WOMEN.

A history of hypersensitivity to ciprofloxacin is a contraindication to its use. A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin.

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Pharmaceutical Division
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West Haven, CT 06516

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C09327 MLR-261

Cipro® TABLETS (ciprofloxacin HCl/Miles)

■ 500 mg *B.I.D.* for most infections; 750 mg *B.I.D.* for severe or complicated infections.

BRIEF SUMMARY
CONSULT PACKAGE INSERT FOR FULL PRESCRIBING INFORMATION

INDICATIONS AND USAGE

Cipro® is indicated for the treatment of infections caused by susceptible strains of the designated microorganisms in the conditions listed below

Lower Respiratory Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Proteus mirabilis, Pseudomonas aeruginosa, Haemophilus influenzae, Haemophilus parainfluenzae,* and *Streptococcus pneumoniae*

Skin and Skin Structure Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Proteus mirabilis, Proteus vulgaris, Providencia stuartii, Morganella morganii, Citrobacter freundii, Pseudomonas aeruginosa, Staphylococcus aureus* (penicillinase and nonpenicillinase-producing strains), *Staphylococcus epidermidis,* and *Streptococcus pyogenes*

Bone and Joint Infections caused by *Enterobacter cloacae, Serratia marcescens,* and *Pseudomonas aeruginosa*

Urinary Tract Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Serratia marcescens, Proteus mirabilis, Providencia rettgeri, Morganella morganii, Citrobacter diversus, Citrobacter freundii, Pseudomonas aeruginosa, Staphylococcus epidermidis,* and *Streptococcus faecalis*

Infectious Diarrhea caused by *Escherichia coli* (enterotoxigenic strains), *Campylobacter jejuni, Shigella flexneri,** and *Shigella sonnei** when antibacterial therapy is indicated

*Efficacy for this organism in this organ system was studied in fewer than 10 infections

Appropriate culture and susceptibility tests should be performed before treatment in order to isolate and identify organisms causing infection and to determine their susceptibility to ciprofloxacin. Therapy with Cipro® may be initiated before results of these tests are known; once results become available appropriate therapy should be continued. As with other drugs, some strains of *Pseudomonas aeruginosa* may develop resistance fairly rapidly during treatment with ciprofloxacin. Culture and susceptibility testing performed periodically during therapy will provide information not only on the therapeutic effect of the antimicrobial agent but also on the possible emergence of bacterial resistance.

CONTRAINDICATIONS

A history of hypersensitivity to ciprofloxacin is a contraindication to its use. A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin.

WARNINGS

CIPROFLOXACIN SHOULD NOT BE USED IN CHILDREN OR PREGNANT WOMEN. The oral administration of ciprofloxacin caused lameness in immature dogs. Histopathological examination of the weight-bearing joints of these dogs revealed permanent lesions of the cartilage. Related drugs such as nalidixic acid, cinoxacin, and norfloxacin also produced erosions of cartilage of weight-bearing joints and other signs of arthropathy in immature animals of various species. (SEE ANIMAL PHARMACOLOGY SECTION IN FULL PRESCRIBING INFORMATION)

PRECAUTIONS

General

As with other quinolones, ciprofloxacin may cause central nervous system (CNS) stimulation, which may lead to tremor, restlessness, lightheadedness, confusion, and very rarely to hallucinations or convulsive seizures. Therefore, ciprofloxacin should be used with caution in patients with known or suspected CNS disorders, such as severe cerebral arteriosclerosis or epilepsy, or other factors which predispose to seizures. (SEE ADVERSE REACTIONS).

Crystals of ciprofloxacin have been observed rarely in the urine of human subjects but more frequently in the urine of laboratory animals. Crystalluria related to ciprofloxacin has been reported only rarely in man, because human urine is usually acidic. Patients receiving ciprofloxacin should be well hydrated, and alkalinity of the urine should be avoided. The recommended daily dose should not be exceeded. Alteration of the dosage regimen is necessary for patients with impairment of renal function. (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION)

Drug Interactions

Concurrent administration of ciprofloxacin with theophylline may lead to elevated plasma concentrations of theophylline and prolongation of its elimination half-life. This may result in increased risk of theophylline-related adverse reactions. If concomitant use cannot be avoided, plasma levels of theophylline should be monitored and dosage adjustments made as appropriate.

Antacids containing magnesium hydroxide or aluminum hydroxide may interfere with the absorption of ciprofloxacin, resulting in serum and urine levels lower than desired; concurrent administration of these agents with ciprofloxacin should be avoided.

Probenecid interferes with the renal tubular secretion of ciprofloxacin and produces an increase in the level of ciprofloxacin in the serum. This should be considered if patients are receiving both drugs concomitantly.

As with other broad-spectrum antibiotics, prolonged use of ciprofloxacin may result in overgrowth of nonsusceptible organisms. Repeated evaluation of the patient's condition and microbial susceptibility testing is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Information for Patients

Patients should be advised that ciprofloxacin may be taken with or without meals. The preferred time of dosing is two hours after a meal. Patients should also be advised to drink fluids liberally and not take antacids containing magnesium or aluminum concomitantly or within two hours after dosing. Ciprofloxacin may cause dizziness or lightheadedness; therefore patients should know how they react to this drug before they operate an automobile or machinery or engage in activities requiring mental alertness or coordination.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Eight *in vitro* mutagenicity tests have been conducted with ciprofloxacin and the test results are listed below:

- Salmonella/Microsome Test (Negative)
- *E. coli* DNA Repair Assay (Negative)
- Mouse Lymphoma Cell Forward Mutation Assay (Positive)
- Chinese Hamster V_{79} Cell HGPRT Test (Negative)
- Syrian Hamster Embryo Cell Transformation Assay (Negative)
- *Saccharomyces cerevisiae* Point Mutation Assay (Negative)
- *Saccharomyces cerevisiae* Mitotic Crossover and Gene Conversion Assay (Negative)
- Rat Hepatocyte DNA Repair Assay (Positive)

Thus, two of the eight tests were positive, but the following three *in vivo* test systems gave negative results:

- Rat Hepatocyte DNA Repair Assay
- Micronucleus Test (Mice)
- Dominant Lethal Test (Mice)

Long-term carcinogenicity studies in animals have not yet been completed.

Pregnancy – Pregnancy Category C

Reproduction studies have been performed in rats and mice at doses up to six times the usual daily human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ciprofloxacin. In rabbits, as with most antimicrobial agents, ciprofloxacin (30 and 100 mg/kg orally) produced gastrointestinal disturbances resulting in maternal weight loss and an increased incidence of abortion. No teratogenicity was observed at either dose. After intravenous administration, at doses up to 20 mg/kg, no maternal toxicity was produced, and no embryotoxicity or teratogenicity was observed. There are, however, no adequate and well-controlled studies in pregnant women. SINCE CIPROFLOXACIN, LIKE OTHER DRUGS IN ITS CLASS, CAUSES ARTHROPATHY IN IMMATURE ANIMALS, IT SHOULD NOT BE USED IN PREGNANT WOMEN. (SEE WARNINGS)

Nursing Mothers

It is not known whether ciprofloxacin is excreted in human milk, however, it is known that ciprofloxacin is excreted in the milk of lactating rats and that other drugs of this class are excreted in human milk. Because of this, and because of the potential for serious adverse reactions from ciprofloxacin in nursing infants, a decision should be made to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use

Ciprofloxacin should not be used in children because it causes arthropathy in immature animals. (SEE WARNINGS)

ADVERSE REACTIONS

Ciprofloxacin is generally well tolerated. During clinical investigation, 2,799 patients received 2,868 courses of the drug. Adverse events that were considered likely to be drug related occurred in 7.3% of courses, possibly related in 9.2%, and remotely related in 3.0%. Ciprofloxacin was discontinued because of an adverse event in 3.5% of courses, primarily involving the gastrointestinal system (1.5%), skin (0.6%), and central nervous system (0.4%).

The most frequently reported events, drug related or not, were nausea (5.2%), diarrhea (2.3%), vomiting (2.0%), abdominal pain/discomfort (1.7%), headache (1.2%), restlessness (1.1%), and rash (1.1%).

Additional events that occurred in less than 1% of ciprofloxacin courses are listed below. Those typical of quinolones are italicized.

GASTROINTESTINAL *(See above),* painful oral mucosa, oral candidiasis, dysphagia, intestinal perforation, gastrointestinal bleeding

CENTRAL NERVOUS SYSTEM *(See above), dizziness, lightheadedness, insomnia, nightmares, hallucinations, manic reaction, irritability, tremor, ataxia, convulsive seizures, lethargy, drowsiness, weakness, malaise, anorexia, phobia, depersonalization, depression, paresthesia*

SKIN/HYPERSENSITIVITY *(See above), pruritus, urticaria, photosensitivity, flushing, fever, chills, angioedema, edema of the face, neck, lips, conjunctivae or hands,* cutaneous candidiasis, hyperpigmentation, erythema nodosum

SPECIAL SENSES *blurred vision, disturbed vision, (change in color perception, overbrightness of lights), decreased visual acuity, diplopia, eye pain, tinnitus, bad taste*

MUSCULOSKELETAL *joint or back pain, joint stiffness,* achiness, neck or chest pain, flare-up of gout

RENAL/UROGENITAL: *interstitial nephritis, renal failure,* polyuria, urinary retention, urethral bleeding, vaginitis, acidosis.

CARDIOVASCULAR palpitations, atrial flutter, ventricular ectopy, syncope, hypertension, angina pectoris, myocardial infarction, cardiopulmonary arrest, cerebral thrombosis

RESPIRATORY epistaxis, laryngeal or pulmonary edema, hiccough, hemoptysis, dyspnea, bronchospasm, pulmonary embolism

Most of these events were described as only mild or moderate in severity, abated soon after the drug was discontinued, and required no treatment.

In several instances, nausea, vomiting, tremor, restlessness, agitation, or palpitations were judged by investigators to be related to elevated plasma levels of theophylline possibly as a result of a drug interaction with ciprofloxacin.

Adverse Laboratory Changes Changes in laboratory parameters listed as adverse events without regard to drug relationship:

Hepatic – Elevations of: ALT (SGPT) (1.9%), AST (SGOT) (1.7%), alkaline phosphatase (0.8%), LDH (0.4%), serum bilirubin (0.3%)

Hematologic – eosinophilia (0.6%), leukopenia (0.4%), decreased blood platelets (0.1%), elevated blood platelets (0.1%), pancytopenia (0.1%).

Renal – Elevations of: Serum creatinine (1.1%), BUN (0.9%)

CRYSTALLURIA, CYLINDRURIA, AND HEMATURIA HAVE BEEN REPORTED

Other changes occurring in less than 0.1% of courses were: Elevation of serum gammaglutamyl transferase, elevation of serum amylase, reduction in blood glucose, elevated uric acid, decrease in hemoglobin, anemia, bleeding diathesis, increase in blood monocytes, and leukocytosis.

OVERDOSAGE

Information on overdosage in humans is not available. In the event of acute overdosage, the stomach should be emptied by inducing vomiting or by gastric lavage. The patient should be carefully observed and given supportive treatment. Adequate hydration must be maintained. In the event of serious toxic reactions from overdosage, hemodialysis or peritoneal dialysis may aid in the removal of ciprofloxacin from the body, particularly if renal function is compromised.

DOSAGE AND ADMINISTRATION

The usual adult dosage for patients with urinary tract infections is 250 mg every 12 hours. For patients with complicated infections caused by organisms not highly susceptible, 500 mg may be administered every 12 hours.

Respiratory tract infections, skin and skin structure infections, and bone and joint infections may be treated with 500 mg every 12 hours. For more severe or complicated infections, a dosage of 750 mg may be given every 12 hours.

The recommended dosage for infectious diarrhea is 500 mg every 12 hours.

In patients with renal impairment, some modification of dosage is recommended. (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION)

HOW SUPPLIED

Cipro® (ciprofloxacin HCl/Miles) is available as tablets of 250 mg, 500 mg, and 750 mg in bottles of 50, and in Unit-Dose packages of 100. (SEE FULL PRESCRIBING INFORMATION FOR COMPLETE INFORMATION)

*** Due to susceptible strains of indicated pathogens. See indicated organisms in Brief Summary.**

CONVENIENT *B.I.D.* DOSAGE

Recommended dosage schedule

Infection Site*	Severity of Infection	Dosage
Respiratory Tract*	Mild/Moderate	500 mg *B.I.D.*
Bone and Joint* Skin/Skin Structure*	Severe/Complicated	750 mg *B.I.D.*
Urinary Tract*	Mild/Moderate	250 mg *B.I.D.*
	Severe/Complicated	500 mg *B.I.D.*
Infectious Diarrhea*	Mild/Moderate/Severe	500 mg *B.I.D.*

For further information, contact the Miles Information Service: 1-800-642-4776. In VA. call collect: 703-391-7888.

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SMS Amendment saves $7 million

An SMS-sponsored state budget amendment lowered fee increases to the Patients Compensation Fund and resulted in a savings of $7 million to Wisconsin health care providers. Having gained Gov Tommy Thompson's approval, the amendment assured that PCF assessments were held to an increase of 10.6%, rather than the 31.7% approved by the PCF Board of Governors in February. The board had requested a veto of the SMS amendment. SMS President J D Kabler, MD, Secretary–General Manager Thomas L. Adams and staff met with Gov Thompson to discuss the issue last spring and received his commmitment to support SMS.

The SMS amendment modified one of the formulas used to establish fund assessments. Now PCF maximum allowable fees may be assessed at 200% of the actual amount disbursed for claims during the previous calendar year instead of estimated total claims paid out during the current fiscal year (the old formula). The rates are compared below.

Physician Class	Proposed (31.7%)	New rate (10.6%)
1	$ 2,758	$ 2,316
2	$ 5,516	$ 4,632
3	$13,790	$11,580
4	$16,548	$13,896

Patient Compensation Fund fees are established annually by insurance commissioner administrative rule and become effective each July 1.■

Kermit L. Newcomer, MD, of La Crosse, was reelected to a three-year term on the AMA Council of Medical Service. The council helps set the official AMA policy position on national socioeconomic issues.

SMS Speakers bureau on substance abuse offers help

Studies have shown that physicians frequently fail to recognize patients with alcohol and other drug abuse problems.

Since this illness has such a devastating effect on the health and welfare of society, and since physicians are in a cardinal position to provide intervention, the SMS Committee on Alcoholism and Other Drug Abuse has developed a speakers bureau to help educate physicians and other professional and community groups about this problem.

Speakers from throughout Wisconsin are available to discuss the following topics:

- Cocaine abuse and treatment
- Impaired professionals, including physicians
- Psychiatric disorders and chemical dependency
- Evaluation and treatment of withdrawal
- Pathophysiology of alcoholism and drug abuses
- AIDS and drug abuse
- Special problems in female, adolescent or geriatric populations
- Many other topics of professional interest

Members of the speakers bureau—who can be contacted either individually or through the SMS—can present individual lectures, a series of presentations, or a workshop tailored to the specific needs of the requesting group.

Speakers Bureau Members

Dane County
Fred J. Koenecke, MD
2727 Marshall Court
Madison, WI 53705
608-238-9354
Topics: depression and chemical dependency; diagnosis of alcoholism; intervention with alcoholics.

Continued on page 21.

WHAT'S THE REAL "BOTTOM LINE?"

When health care leaders get together these days, the terminology seems considerably different than not so long ago. Without question, business terms have their place in health care today –terms like "trend correlation... segmentation... **bottom line.**"

But, when you need to refer your patient for psychiatric treatment, we thought you might like to know that somebody still remembers that the real "bottom line" is quality patient care.

St. Mary's Hill Hospital... the family-centered psychiatric hospital.

If you would like information on the services of St. Mary's Hill Hospital, call or write our Medical Director, Wess R. Vogt, M.D.

SAINT MARY'S HILL HOSPITAL

2350 North Lake Drive Milwaukee, Wisconsin 53211 414/271-5555

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Continued from page 19.

Harry McCormick, MD
5706 Odana Road
608-271-7780
Topics: adolescent AODA; overview of chemical dependency; cocaine and other IV drug abuse; AIDS and drugs.

David L. Nelson, MD
PO Box 190
Stoughton, WI 53589
608-873-7772
Topics: treatment of chemical dependency in a small community hospital; chemical dependency in a general practice.

Fond du Lac County
Sherry Stormo
270 Sheboygan St
Fond du Lac, WI 54935
414-922-1298
Topics: recognition of abuse.

Lincoln County
Charles Goodell, MD
Sacred Heart Hospital
216 N 7th St
Tomahawk, WI 54487
715-453-2181
Topics: diagnosis of alcoholism; treatment of withdrawal; disease of alcoholism.

Manitowoc County
Harry M. McCormick, MD
2651 S 8th St
Manitowoc, WI 54220
Call Madison: 608-271-7780
Topics: adolescent AODA; overview of chemical dependency.

Marathon County
Thomas H. Peterson, MD
995 Campus Drive
Wausau, WI 54401
715-675-3391
Topics: alcoholism and chemical abuse (general topics).

Milwaukee County
Ashok R. Bedi, MD
1220 Dewey Ave
Wauwatosa, WI 53213
414-258-6000
Topics: alcoholism, drug addiction and psychiatric disorders.

David Benzer, DO
1220 Dewey St
Wauwatosa, WI 53213
414-258-2600
Topics: cocaine addiction; overview of chemical dependency.

Roland E. Herrington, MD
1220 Dewey Ave
Wauwatosa, WI 53213
414-258-2600
Topics: cocaine dependency, diagnosis and treatment.

Wess Vogt, MD
Ivanhoe Treatment, Inc
2203 E Ivanhoe Place
Milwaukee, WI 53202
414-964-4830
Topics: dual diagnosis; alcoholism, evaluation and detection.

Monroe County
Edward O. Lukasek, MD
615 Pearl St
Sparta, WI 54656
608-269-4756
Topics: physiological and overall effects of alcohol and other drugs.

Racine County
Warren H. Williamson, MD
500 Walton Ave
Racine, WI 53402
414-633-3070
Topics: pathophysiology of drug abuse

Wood County
Gurdon H. Hamilton, MD
1000 N Oak Ave
Marshfield, WI 54449
Topics: alcoholism in general medicine; elderly alcoholism.

John P. Kirchner, MD
AODA Program
Marshfield Clinic
1000 N Oak Ave
Marshfield, WI 54449
715-387-5511
Topics: affects of alcohol and other drugs on the gastrointestinal system.

For further information, contact the State Medical Society at PO Box 1109, Madison, WI 53701, or phone 1-800-362-9080 or 608-257-6781.■

Beating the heat: SMS President J D Kabler, MD, and Secretary-General Manager Thomas L. Adams held a press conference at SMS headquarters in Madison June 24 to caution Wisconsin citizens about the health hazards of this summer's heat wave and drought and offer advice on minimizing the risks. Dr Kabler's remarks were also mailed to news media throughout the state, and the story was widely reported in print and over the airwaves.■

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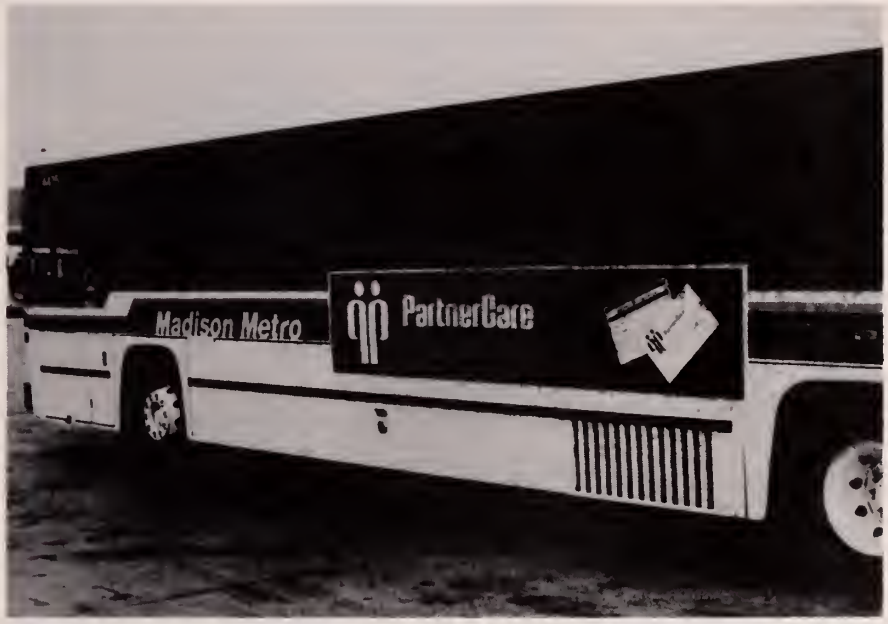
PartnerCare takes to the airwaves

The State Medical Society of Wisconsin and the Wisconsin Broadcasters Association have embarked on a cooperative effort to increase the visibility of PartnerCare among potential elderly participants in the state. The two groups produced 30-second public service announcements about the program that were distributed to more than 100 radio and television stations in Wisconsin in early July. A joint effort of the SMS and the Coalition of Wisconsin Aging Groups, PartnerCare is a voluntary Medicare assignment program for low-income senior citizens. Across the state, more than 5,000 physicians have agreed to take part in the program.

The production of the PartnerCare spots is the latest in a series of efforts between the two groups to educate the public on health issues; other public service announcements have focused on the responsible use of alcohol and fetal alcohol syndrome.

Meanwhile, the Wisconsin Physicians Service Insurance Corporation (WPS) has provided a grant of $6,000 to the PartnerCare program. This donation will help continue funding for VISTA workers in training volunteers and county aging workers in the certification of potential participants. The money was urgently needed due to a lapse in federal ACTION funding, and WPS was the only health care-related agency in the state to respond to the SMS appeal for funds.

In related news, two physicians have been added as members of the PartnerCare working group. They are Nicholas L. Owen, MD, of Milwaukee, and Bruce A. Kraus, MD, of Columbus. The group, which is chaired by Kenneth M. Viste, Jr, MD, immediate past president of SMS, was created by the Board of Directors at the annual meeting to oversee the continuing implementation of the program across the state.■



Spreading the word: The PartnerCare message was carried to the public on 20 Madison Metro buses during July. The members of the Dane County Medical Society provided funding for the bus advertisements, as well as ads and announcements in area publications serving senior citizens.

Physician briefs

* *Indicates SMS members.*

Gary L. Preisler, DO,* has joined the staff of General Clinic in West Bend. A graduate of the University of Wisconsin–Madison with a degree in pharmacy, Dr Preisler also graduated from the University of Osteopathic Medicine and Health Sciences in Des Moines. He served a family practice residency at St Michael Hospital in Milwaukee.

Jeffrey P. Holmgren, MD, recently joined the medical staff at Memorial Medical Center in Ashland. Dr Holmgren graduated from the University of Minnesota School of Medicine and completed a residency in psychiatry at the Vanderbilt University Hospital in Nashville.

Kathy Keimig, MD, a family practice physician, recently opened a medical practice in Hayward. Dr Keimig graduated from the University of South Dakota School of Medicine and completed her internship and residency at the University of North Dakota Family Practice Center.

Alwin E. Schultz, MD,* of Madison, recently retired after nearly 40 years of practice. Dr Schultz was president of the Dane County Medical Society in 1982. He graduated from the University of Wisconsin Medical School in Madison.

Edward Worthington Parker

When this store opened in 1857, who would have dreamed that the diamond your great grandfather gave your great grandmother would be worth 5–10 times as much? And who would have dreamed that watches would keep time within seconds per month and run for months on a battery the size of an aspirin?

As founder, I said, "The most valued asset of our firm is its unchallenged reputation for honest dealings, quality products and expert workmanship. Since we were friends, doing business with friends, we were quite frank about the quality of a diamond or the complexity of a watch."

"Much has changed in the intervening 131 years. I'm glad my family is still around to give you the same good service and expert counsel we took so much pride in way back then!"

"Stop in and meet my grandson, his wife and my great-grandson."

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Patricia M. McGuire, MD,* and **John S. Davis, MD,** recently joined the medical staff at Marshfield Clinic. A pediatrician, Dr McGuire previously was in private practice in Chippewa Falls. She received her medical degree from St Louis University School of Medicine and completed a residency at Mayo Clinic in Rochester, Minn, and Gundersen Medical Foundation in La Crosse. Dr Davis, a specialist in angiography and interventional radiology, graduated from Oregon Health Sciences University in Portland and served an internship and residency there as well.

Geoffrey C. Kloster, MD,* a family practice specialist, has joined the Galesville Medical Clinic. Dr Kloster received his medical degree from the St Louis University School of Medicine and completed a residency with the Midland Hospital Association in Midland, Mich. Previously he was with the Family Medical Clinic in Merrill.

Frederick L. Whitlark, MD,* recently retired after 39 years of practice in Amery. He graduated from the University of Illinois and interned at St Mary's Hospital in Detroit.

Leighton P. Mark, MD, was recently appointed assistant professor of radiology at the Medical College of Wisconsin. He received his degree from the New York University School of Medicine and served a diagnostic radiology residency at Dartmouth-Hitchcock Medical Center in Hanover, NH.

John J. Byrne, MD,* of Racine recently joined the Racine Medical Clinic. An internist, Dr Byrne graduated from the Medical College of Wisconsin in Milwaukee and served his residency at Evanston Hospital in Evanston, Ill.

Nancy L. Betzold, MD,* recently joined the staff at Memorial Medical Center in Ashland. A family practice

physician, Dr Betzold graduated from the Medical College of Wisconsin in Milwaukee. She served a residency at the Waukesha Memorial Hospital and the Medical College of Wisconsin.

Mark E. Mering, MD, recently joined the Luther Hospital emergency room staff. He received his medical degree from the University of North Dakota–Grand Forks and completed a family practice residency at the University of Arizona–Tucson.

Steven L. Kidd, MD,* a general surgeon, recently joined the Rhinelander Medical Center, SC. Dr Kidd graduated from the University of Minnesota Medical School in Minneapolis and completed a residency at Chicago Medical School.

Randy Rudisill, MD, recently joined Medical Associates of Beloit as a family physician. He graduated from the University of Illinois in Chicago and completed a residency at Lutheran General Hospital in Park Ridge, Ill.

Mark R. Hendricks, MD, recently joined Internal Medicine Associates of Manitowoc in Two Rivers. Dr Hendricks graduated from the University of Minnesota and completed his internship and residency in internal medicine at Gundersen Clinic and Lutheran Hospital in La Crosse.

Norman J. Schroeder, II, MD,* of Two Rivers recently was named assistant medical director at Employers Health Insurance. Previously, Dr Schroeder practiced family medicine in Beaver Dam and was an emergency room physician at Holy Family Medical Center in Manitowoc. He recently received his MBA from the University of Wisconsin–Milwaukee.

Lloyd P. Maasch, MD, of Weyauwega, recently was named Wisconsin Physician of the Year by the Wisconsin Academy of Family Physicians at its annual meeting in Stevens Point. Dr Maasch received his medical degree from Marquette University

Continued on page 26.

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The persons and organizations named below made contributions to the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin during the month of March 1988. The Foundation and the Society salute their generosity.

Voluntary Contributions

Jeffrey J. Brook, MD
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In Memoriam

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Joe Miller
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Charles L. Qualls, MD
Mrs Rhea Schulz
Walter J. Urben, MD
Kevin P. Wong, MD

Earl R. Thayer Lecture Fund

Earl and Alice Thayer■

Continued from page 25.

and served an internship at St Joseph's Hospital in Milwaukee. He has served as a delegate to the SMS for 25 years and has been the Waupaca County Coroner since 1982.

Dean B. Pratt, MD,* and **Sara J. Pratt, MD,*** of Sheboygan were recently awarded the 1988 Distinguished Service Award by the Sheboygan Memorial Health Foundation's Ambassador's Club for contributions to the health of Sheboygan County residents.

Richard A. Pierce-Ruhland, MD, of Racine, recently joined the Racine Medical Clinic. Dr Pierce-Ruhland, an internist, graduated from the University of Texas Health Science Center in San Antonio and served a residency at Northwestern University Medical Center in Chicago.

Steven Bernstein, MD, has joined the Burlington Clinic. A urologist, Dr Bernstein previously was in private practice in Pittsburgh. He graduated from the State University of New York and served a residency at Downstate Medical Center in Brooklyn, NY.

Mark Crapster-Pregont, MD, and **Barbara Crapster-Pregont, MD,** recently joined the Family Medical Clinic in Merrill. Both physicians received their medical degrees at the University of Connecticut and completed family practice residencies in Eau Claire.

R. Nolan Hetz, MD,* recently joined Surgical Associates, SC, in Manitowoc. A specialist in obstetrics and gynecology, Dr Hetz received his medical degree from the Southern Illinois University School of Medicine. He served a residency at Franklin Square Hospital Center in Baltimore.

Morgan E. Warffuel, MD, has joined the Monroe Clinic in Brodhead. He graduated from American University–Caribbean School of Medicine and interned at McKeesport Hospital in McKeesport, Pa. He served a residency at Good Samaritan Medical Center in Milwaukee, which is affiliated with the Medical College of Wisconsin.

Zatchel J. Soto, MD, recently joined Tomahawk Medical Center. A native of Puerto Rico, Dr Soto earned his medical degree at the University of Central del Este in San Pedro, Dominican Republic. He served a residency in family practice at St Mary's of Nazareth Hospital Center in Chicago. ■

CES Foundation of the State Medical Society of Wisconsin

The persons and organizations named below made contributions to the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin during the month of April 1988. The Foundation and the Society salute their generosity.

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Jean Bake
Arthur D. Bussey, MD
Steve L. Chojnacki, MD
John L. Colgan, MD
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Memorials

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Dane County Medical Society
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Capsule or tablet slow-release potassium chloride preparations should be reserved for patients who cannot tolerate, refuse to take, or have compliance problems with liquid or effervescent potassium preparations because of reports of intestinal and gastric ulceration and bleeding with slow-release KCl preparations.

Before prescribing, please consult Brief Prescribing Information on next page.

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†Pooled mean serum potassium following oral administration of 30 mEq K-Tab compared to 24 mEq Slow-K in diuretic-treated hypertensives (n = 20) over 8 weeks.

CIBA

References: 1. Data on file, CIBA Pharmaceutical Company **2.** Skoutakis VA, Acchiardo SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride Bioavailability and safety *Pharmacotherapy* 1980;4(6):392-397. **3.** Skoutakis VA, Carter CA, Acchiardo SR: Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics *Drug Intell Clin Pharm* 1987;21:436-440

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Slow-Release Tablets
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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE INSERT)

INDICATIONS AND USAGE
BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.
1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.
2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function, potassium-losing nephropathy; and certain diarrheal states.
3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS
Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS
Hyperkalemia (See OVERDOSAGE).
In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics
Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions
Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis
Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS
General:
The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients
Physicians should consider reminding the patient of the following:
To take each dose without crushing, chewing, or sucking the tablets.
To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.
To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.
To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests
Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions
Potassium-sparing diuretics: see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility
Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C
Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers
The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use
Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE
The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSAGE AND ADMINISTRATION
The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

HOW SUPPLIED
Tablets—600 mg of potassium chloride (equivalent to 8 mEq) round, buff colored, sugar-coated (imprinted Slow-K)

Bottles of 100	NDC 0083-0165-30
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AMA House acts on three Wisconsin resolutions

The AMA House of Delegates at its annual meeting in Chicago took action on three resolutions offered by the Wisconsin delegation. Resolution 142, which was adopted, urges Congress and the president to enact comprehensive clean ambient air legislation. A second resolution (143) offered by the state delegation and adopted as amended directs the AMA to work with Blue Cross–Blue Shield, federal agencies, and other groups to develop a uniform definition for investigational or experimental therapies and procedures and to establish a method for providing information about the status of certain treatments.

Resolution 144 calls on the AMA to continue to monitor and evaluate all proposed health insurance legislation, including the Minimum Health Benefits for All Workers Act (SB 1265), to address the problem of the growing numbers of uninsured workers in the US. This resolution was referred to the Board of Trustees for study.

In the other action the AMA House of Delegates:

- Sent to the Board of Trustees a plan to create a new category of health care worker, the registered care technologist or RCT, to help alleviate the nursing shortage;
- Approved a report by the Center for Health Policy Research projecting that the supply of physicians by the year 2000 will exceed demand by 9.4%, but stopped short of calling it a surplus, saying many other factors had to be taken into account in defining it as such (highest excesses are expected in emergency medicine, pediatrics and obstetrics-gynecology);
- Approved a report commissioned by the board showing that physicians receive less than their customary fee for services rendered to Medicare and Medicaid recipients (in 1986, physicians received an average of 59 to 79 cents for every dollar billed to a Medicare patient, according to the study);
- Approved criteria for judging the Harvard resource-based relative value scale (RBRVS) to be submitted to the Health Care Financing Administration (HCFA) at the end of July;
- Voted to urge the federal government to amend the criteria for Medicaid eligibility, which would increase those eligible for the program from 19 million to 46 million persons, and to increase payments for physician and hospital services closer to Medicare levels;
- Supported AIDS contact tracing;
- Supported ending lower diagnosis-related groups (DRG) payments to rural hospitals;
- Debated a number of resolutions and reports relating to Medicare contracts and reimbursements.

In his inaugural address, incoming AMA President James E. Davis, MD, urged physicians to spend four hours a week in public service and called on every physician organization in the country—including state, county, and specialty groups—to organize and staff ombudsman offices as a two-way liaison between physicians and the public. "The point is, we all must let the public know we care," Dr Davis said.■

CES Foundation
of the State Medical Society of Wisconsin

The persons and organizations named below made contributions to the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin during the month of May 1988. The Foundation and the Society salute their generostiy.

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Dane County Medical Society
The Richard Edwards, MD, Family
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Dr and Mrs Robert Schmidt
Marlene and Bill Wendle■

Re-introduce The Oldest Advance In Medicines.

It's called talking. Right or wrong, many older people today feel that doctors just don't spend as much time talking with their patients as they used to. Things seem more rushed and hurried.

But talking, especially about medicines, is more important than ever before. Your older patients may be taking several different medicines and seeing more than one doctor. And many older people are treating themselves with over-the-counter drugs.

Unfortunately, an older person's response to medicines is less predictable than a younger person's. They can experience altered drug actions and adverse drug reactions.

So, if they don't tell you first, ask them what they're taking and if the medicines are causing any problems. Take a complete medications history including both prescription *and* non-prescription medicines.

Make it a point to tell them what they need to know — the medicine's name, how and when to take it, precautions, and possible side effects. Give them written or printed information they can take home, and encourage them to write down what you tell them.

Good, clear communication about medicines can increase compliance, prevent problems, and lead to better health.

So re-introduce the oldest advance in medicines. Make talking a crucial part of your practice. It isn't a thing of the past. It's the way to a healthier future.

Before they take it, talk about it.

National Council on
Patient Information and Education.
666 Eleventh St. N.W. Suite 810
Washington, D.C. 20001

Obituaries

Edward J. Schneeberger, MD, 79, La Crosse, died December 28, 1987, in La Crosse. Born March 19, 1908, in La Crosse, Dr Schneeberger graduated from Marquette University School of Medicine and served his internship at St Mary's Hospital in Milwaukee. He was a member of the La Crosse County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Tracy; four daughters, Judith Wiltinger, La Crosse; Mary Deardorff, Downers Grove, Ill; Rita Walsh, Oak Lawn, Ill; Therese Dobson, La Crosse; and three sons, Thomas, Monroe; John, Sun Prairie, and E. Michael of Stevens Point.

Leslie G. Kindschi, MD, 81, Monroe, died May 2, 1988, in Monroe. Born June 3, 1906, in Madison, Dr Kindschi graduated from Harvard Medical School, Boston, Mass, and served his internship at Cleveland City Hospital. His residency was completed at the Cleveland Clinic and at Mayo Clinic in Rochester, Minn. Dr Kindschi joined the medical staff of The Monroe Clinic in 1941 and retired from his medical practice in 1983. He served with the United States Navy Medical Corps from 1943 to 1946. In 1948, he began a preceptorship for senior medical students at The Monroe Clinic and was the recipient of the Max Fox Preceptorship Award in 1972. Dr Kindschi was appointed a member of the *Wisconsin Medical Journal*'s Editorial Board in 1960 and served until 1975. He was a fellow in the American College of Physicians and a member and past president of the Wisconsin Society of Internal Medicine. Dr Kindschi was a member of the Green County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are two sons, George Kindschi, MD, Monroe; Kim Kindschi of Madison; and a daughter, Mrs John (Karen) Waggoner, Madison, and eight grandchildren.

Leander J. Van Hecke, MD, 80, Whitefish Bay, died May 6, 1988, in Sun City, Ariz. Born August 14, 1907, in Stevens Point, Dr Van Hecke graduated from Marquette University School of Medicine and served his internship and residency at Milwaukee County General Hospital. He was Milwaukee County's part-time medical examiner from 1951 to 1966. He was a member of the Wisconsin Society of Pathologists, The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. Survivng are his widow, Dorothy; three daughters, Mary Lorraine Benthal, Charleston, SC; Phoebe Segal, Glencoe, Ill; Holly Kellner, Chicago, Ill; three sons, Charles, Colgate; F.M., Grafton; and Mark of New York City; and two stepchildren, Peter Allen, West Bend, and Mary Stitt of Port Washington.

Michael Barton, MD, 69, Janesville, died May 12, 1988, in Janesville. Born January 13, 1919, in Warsaw, Poland, Dr Barton graduated from the University of Basel in Switzerland, and served his internship and residency in Kansas City, Mo, Cleveland, Ohio, Philadelphia, Penn, and Charleston, West Va. Surviving are his widow, Carol; and three daughters, Devorah Yahn, Viroqua; Michelle, Providence, RI; Jessica, Rochester, NY, and one son, Michael of Phoenix, Ariz.

CES Foundation
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The persons and organizations named below made contributions to the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin during the month of June 1988. The Foundation and the Society salute their generosity.

Voluntary Contributions

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—Museum Refurbishment
Wisconsin Physician Service
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Beaumont 500 Club

Oconto County Medical Society

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Kathy Mohelnitzky
State Medical Society of Wisconsin
Norma Swenson

In Memoriam

James W. Barreau
Kermit M. Covell, MD
James E. Geigler, MD
Benn Spalding Hill, MD
Leslie Kindschi, MD
Jaime McClure
E. Allen Miller, MD
E. Grady Mills, MD
Cecil A. Morrow, MD
Robert E. Urbanek, MD
Rick R. Wartgow, MD■

Erwin E. Grossmann, MD, 77, Whitefish Bay, died May 12, 1988, in Milwaukee. Born January 2, 1911, in Germany, Dr Grossmann graduated from the University of Wisconsin Medical School, Madison, and served his internship at St Louis Jewish Hospital in Missouri. His residency was completed at the Illinois Eye & Ear Infirmary in Chicago, Ill. Dr Grossmann served in the United States Army Medical Corps from 1941 to 1946. He was an assistant professor at the University of Illinois College of Medicine. Dr Grossman was a member of the American College of Surgeons, American Academy of Ophthalmology-Otolaryngology, and the Milwaukee Ophthalmology Society. He also was an associate clinical professor at Marquette Medical School. Dr Grossmann was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Helen; and two daughters, Beth Shapiro, Bayside, and Lynn Preizler of Madison.

John W. Wurster, MD, 78, Wauwatosa, died May 12, 1988, in Wauwatosa. Dr Wurster had a private medical practice in Pocatello, Idaho, before moving to Wauwatosa. He had been a member of the Clement Zablocki Medical Center until he retired in 1983. Surviving are his widow, Evelyn; two sons, John of Texas; Richard of Greenfield; and one daughter, Suzanne Foster of Illinois.

Lawrence R. Gowan, Jr, MD, 58, Tomah, died May 15, 1988, in Tomah. Born March 23, 1930, in Duluth, Minn, Dr Gowan graduated from Marquette University School of Medicine and served an internship and pathology residency at St Mary's Hospital in Duluth. Following his service in the United States Navy from 1958 to 1960, he served a psychiatry residency at the Mayo Clinic in Rochester, Minn. Dr Gowan was chief of the Department of Psychiatry at Tomah Veterans Administration Medical Center. Surviving are his widow, Mary K; two sons, Peter, Madison, and Patrick of Tomah; and two daughters, Angela, Minneapolis, and Juliana of San Angelo, Tex.

James E. Geigler, MD, 61, Elm Grove, died May 22, 1988, in Milwaukee. Born December 9, 1926, in Milwaukee, Dr Geigler graduated from Marquette University School of Medicine and served his internship at Deaconess Hospital in Milwaukee. He served in the United States Navy from 1944 to 1946. Dr Geigler had practiced medicine in the Milwaukee area for 34 years. He was a member and past president of the Southeastern Wisconsin Chapter of the American Academy of Family Physicians, a diplomate of the American Board of Family Practice, and a member of the Marquette University-Medical College of Wisconsin Alumni Association. Dr Geigler was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Elaine; four sons, Gary, Maple Grove, Minn; Grant, Wheaton, Ill; Gregg, Waukesha; Glenn, Des Plaines, Ill, and one daughter, Gail Schahczinski of Oak Creek.

Harold P. Rusch, MD, 79, Madison, died May 26, 1988, in Madison. Born July 15, 1908, in Merrill, Dr Rusch graduated from the University of Wisconsin Medical School, Madison, and served an internship at the University Hospitals in Madison. He was a Bowman Research Fellow in 1935, and from that time devoted his entire career in cancer research. He founded and served as the director of the McArdle Memorial Laboratory for Cancer Research from its beginning in 1940 until 1972. Dr Rusch organized and became director of the Wisconsin Clinical Cancer Center at the University of Wisconsin–Madison, a post he held until his retirement in 1978. He served as president of the American Association for Cancer Research from 1954 to 1955 and as president of the Association of American Cancer Institutes from 1972 to 1974. He was a member of the Commission on Cancer Research of the International Union Against Cancer from 1958 to 1966. He also served on the editorial boards of a number of scientific journals. He was a member of President Kennedy's Committee on Heart Disease and Cancer in 1961, and he was appointed to the US Senate National Panel of Consultants on the Conquest of Cancer in 1970. He was a member of the American Cancer Society and in 1970 he received the Annual Wisconsin Divisional Award of the American Cancer Society, and in 1972 the Annual National Award. Dr Rusch was a fellow of the American Academy of Arts and Science in 1959. He received the Distinguished Service Award of the University of Wisconsin Alumni Association in 1970, and in 1972 the UW Medical Alumni Citation. In 1981 he received the Papanicolaou Award from the Papanicolaou Institute in Miami. Dr Rusch is survived by his widow, Louise Turner Van Wart Rusch, a daughter, Mrs George (Carolyn) Schlotthauer, and two grandchildren.

Thomas J. Pendergast, MD, 75, Wauwatosa, died June 1, 1988, in Wauwatosa. Born February 24, 1913, in Milwaukee, Dr Pendergast graduated from Marquette University School of Medicine and served his internship at Milwaukee County Hospital. Dr Pendergast was a staff surgeon at St Francis Hospital from 1956 to 1984 and chief of surgery from 1960 to 1963. He also was a member of the medical staff at St Joseph's and Milwaukee County General hospitals. He was an assistant clinical professor of surgery at The Medical College of Wisconsin. He was a member of The Medical Society of Milwaukee County, the State

Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Bernardine; five sons, John, New Haven, Conn; Thomas, Madison; James, Michael, and Patrick, Milwaukee; three daughters, Mary Vladeck, Washington, DC; Jane, Gainesville, Fla, and Ann Christman of Brookfield.

Rick R. Wartgow, MD, 30, Milwaukee, died April 30, 1988, in Milwaukee. Born March 26, 1958, in Butternut, Dr Wartgow graduated from the Medical College of Wisconsin in 1983 and served his internship at Franklin Square Hospital in Baltimore, Md. He was serving his residency at Mount Sinai Medical Center in Milwaukee. He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association. Surviving is his widow, Michelle.

Zebedee J. Nevels, MD, 61, Milwaukee, died June 2, 1988, in Milwaukee. Born November 13, 1926, in Nowata, Okla, Dr Nevels graduated from Howard University School of Medicine, Washington, DC, and served his internship at Freedman's Hospital in Washington, DC. His residency was completed at the Veterans Administration Hospital, Tuskegee, Ala; Mount Sinai Hospital, Milwaukee; Veterans Administration Hospital, Wadsworth, Kan, and St Luke's and Children's Hospitals in Kansas City, Mo. He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Virginia, and two children.

Abraham I. Greenberg, MD, 81, Milwaukee, died June 3, 1988, in Milwaukee. Born May 29, 1907, in New York, Dr Greenberg graduated from Marquette University School of Medicine and served his internship at St Joseph's Hospital in Marshfield. Dr Greenberg was a member of the American Academy of Family Physicians, The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are two children, Phyllis Gold, Wilmette, Ill, and Lawrence Greenberg, MD, of Boston, Mass.■

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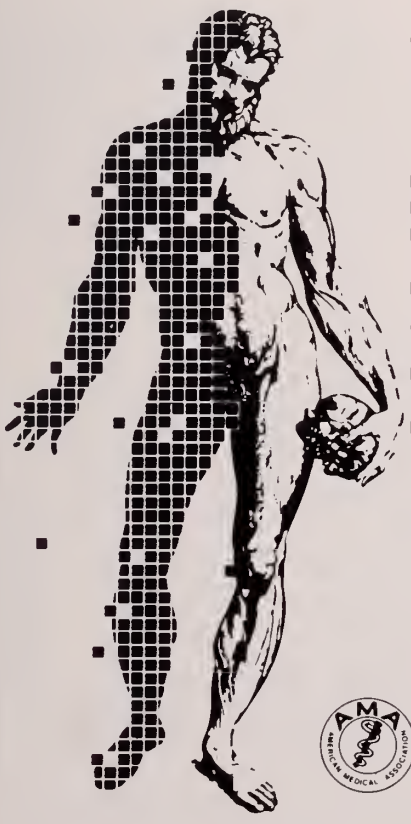

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Sarah Schwartz

New SMS AIDS training coordinator

Sarah Schwartz joined the SMS in June as the AIDS training coordinator for Wisconsin. Part of a cooperative effort with the University of Illinois and funded by a three-year grant from the US Health Resources and Services Administration, the SMS program will train physicians, nurses and other health care professionals in HIV treatment and prevention. Schwartz is a registered nurse and was previously employed with WPS, where she was supervisor of provider education.

Senior Physicians to meet

The Wisconsin Association of Senior Physicians will hold its annual meeting Sept 10 at the Madison Club in Madison. SMS Secretary–General Manager Thomas L. Adams is a featured speaker. The keynote speaker will be named at a later date.

Physicians who are at least 60 and who are retired or semiretired are eligible to join Senior Physicians. For more information, contact Kristin Bjurstrom Krueger at 1-800-362-9080 or 608-257-6781.■

Blue Book update

Please refer to page 96 of the July 1988 Blue Book edition of the *WMJ*. The following physicians have been appointed to the new SMS Task Force on the Uninsured:

- Kermit Newcomer, MD, of La Crosse (chair);
- John K. Scott, MD, of Madison;
- Kenneth M. Viste, Jr, MD, of Oshkosh;
- DeLore Williams, MD, of West Allis;
- Frank H. Urban, MD, of Milwaukee; and
- Susan M. Haack, MD, of Madison.

Besides the physician members, representatives from the following groups will also serve in the task force: National Federation of Independent Business, Wisconsin Physicians Service, Wisconsin Hospital Association, Wisconsin Manufacturers and Commerce, Commissioner of Insurance, Blue Cross–Blue Shield United, and the Coalition of Wisconsin Aging Groups.

Please refer to page 115 of the July 1988 Blue Book edition of the WMJ. The new officers of the Wisconsin Society of Radiation Oncologists, serving until June 1990, are:

Homer H. Russ, MD, (president)
611 St Joseph Ave
Marshfield, WI 54449

Sally M. Schlise, MD,
(vice president)
St Vincent Hospital
835 S Van Buren
Green Bay, WI 54305

Richard A. Steves, MD, (secretary)
K4/B100 UW CSC
600 Highland Ave
Madison, WI 53792.

Please refer to page 96 of the July 1988 Blue Book edition of the *WMJ*. The members of the newly formed SMS Blue Ribbon Task Force on Alternatives to the Tort System are:

- Thomas L. Adams, secretary–general manager, SMS, Madison,
- Gordon Baldwin, professor, University of Wisconsin Law School, Madison,
- Steve Dickmann, Nelson Industries, Stoughton,
- John Duncan, Metropolitan Milwaukee Association of Commerce,
- Robert D. Haase, state commissioner of insurance, Madison,
- David Helbach, state senator, 24th Senate District, Stevens Point,
- C. Robert Jackson, MD, Madison,
- William J. Listwan, MD, West Bend,
- John Parr, AFCME Council 48, Milwaukee,
- Richard G. Roberts, MD, Madison,
- Peggy A. Rosenzweig, state representative, 98th Assembly District, Wauwatosa,
- John O. Simenstad, MD, Osceola,
- William L. Treacy, MD, Milwaukee,
- Darold A. Treffert, MD, Fond du Lac, and
- Roger L. von Heimburg, MD, Green Bay (chair).■

A call for photographs

The *Wisconsin Medical Journal* and the SMS Charitable, Educational, and Scientific Foundation are joining forces in an effort to build a photographic library of medicine in Wisconsin. All photos relating to medicine—persons or places, equipment or events—are welcome and tax deductible. Send your photos to: Kristin Bjurstrom Krueger, State Medical Society of Wisconsin, PO Box 1109, Madison, WI 53701-1109.■

ARMY RESERVE MEDICAL PROFILE NO. 5

ROSALYN P. STERLING-SCOTT, M.D.

Assistant Professor of Surgery, UCLA School of Medicine and Drew University of Medicine and Science, Los Angeles

Associate Surgeon, Department of Cardiovascular & Thoracic Surgery, Centinela Hospital Medical Center, Los Angeles

Major, U.S. Army Reserve

EDUCATION Rensselaer Polytechnic Institute, Troy, NY, B.S. Chemistry; NYU School of Medicine, New York, M.D.

RESIDENCY Boston University School of Medicine (Cardiovascular); Saint Vincent's and St. Claire's Hospitals, New York City (General Surgery)

FELLOWSHIP First Mary A. Fraley Cardiovascular Surgical Research Fellow at the Texas Heart Institute, Houston

OUTSTANDING ACHIEVEMENTS Author of numerous articles, including "Indications for Early Bypass Grafting Following Intracoronary Streptokinase"; author of "The Female Surgeon—Dawn of a New Era," chapter in *A Century of Black Surgeons—The U.S.A. Experience*; Board of Directors, Association of Black Cardiologists; Secretary, Drew Society

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duodenal ulcer therapy available in a

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AXID®
nizatidine capsules

Brief Summary. Consult the package insert for prescribing information.

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients, at a reduced dosage of 150 mg h.s. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

Drug Interactions—No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system, therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice; although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Overdosage: There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LO_{50} values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

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Axid® (nizatidine, Lilly)

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Indianapolis, Indiana
46285

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State Medical Society of Wisconsin

1988

Membership Directory

as of August 1, 1988

Listed in alphabetical order and by county medical society.

This directory includes member's name, address, telephone number (when provided), primary and secondary practice specialties, and board-certified specialties and subspecialties. Members received a verification form on the covers of the March and April issues of the *WMJ* for correcting membership records used in this listing.

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State Medical Society of Wisconsin
PO Box 1109, Madison, WI 53701

How the directory was compiled

Information in this directory has been provided by the staff in Membership Records after each Society member was given the opportunity to verify its accuracy by returning a verification form which appeared on the "false" front cover of the March and April issues of the *Wisconsin Medical Journal.* This directory is reproduced from the computer printout of the SMS membership records. The computer program allows members to designate up to three specialties (primary, secondary, tertiary) in which they practice. These specialty designations appear in the directory on the last line of each member listing before the slash (/). Also on the last line after the slash (/), members are allowed to designate up to three specialties or subspecialties in which they are board-certified.

The SMS recognizes the practice specialties used by the AMA in its *American Medical Directory,* which includes data collected on board certification from physicians themselves and from the American Board of Medical Specialties in its publication, *Compendium of Certified Medical Specialists.* Only those certifications from the 23 boards included in the *Compendium* are included in this directory.

Practice specialties and board certifications listed in the SMS membership records have been provided by individual members who annually update this information for the *SMS Membership Directory.* In neither case has the specialty or certification designations been routinely verified with any other source. The specialty codes used in this directory are used for record-keeping and do not imply recognition or endorsement of any field of medicine. They are intended for use in this directory only and are not to be used for changing or updating other records. The SMS, its officers, agents and employees make no claims as to accuracy, nor accept liability for information that may not be correct, or for errors and omissions.

AMA codes for self-designated practice specialties and the board-certified specialties appear elsewhere in this issue.

Correction Form

Members whose listing in this directory is not accurate are urged to submit changes to Membership Records on the form below. Such changes will be published in subsequent issues of the *WMJ.*

TO: Membership Records, State Medical Society of Wisconsin, PO Box 1109, Madison, WI 53701

Please correct the information used in the 1988 Membership Directory on your records as follows:

COUNTY MEDICAL SOCIETY _____

PRACTICE SPECIALTIES
(use codes from list)

			/
PRIMARY	SECONDARY	TERTIARY	

BOARD-CERTIFIED
SPECIALTIES
(use codes from list)

/			
	PRIMARY	SECONDARY	TERTIARY

TELEPHONE # _____

NAME _____

STREET _____ SUITE/APT #_____

PO BOX #_____

CITY _____ STATE _____ ZIP _____

SIGNED _____ DATE _____

AMA Self-designated practice specialties (primary and secondary) with codes.

- ☐ A Allergy
- ☐ ABS Abdominal Surgery
- ☐ ADL Adolescent Medicine
- ☐ AI Allergy & Immunology
- ☐ AM Aerospace Medicine
- ☐ AN Anesthesiology
- ☐ ATP Anatomic Pathology

- ☐ BLB Blood Banking

- ☐ CCM Critical Care Medicine
- ☐ CD Cardiovascular Diseases
- ☐ CDS Cardiovascular Surgery
- ☐ CHN Child Neurology
- ☐ CHP Child Psychiatry
- ☐ CLP Clinical Pathology
- ☐ CMP Chemical Pathology
- ☐ CRS Colon & Rectal Surgery

- ☐ D Dermatology
- ☐ DIA Diabetes
- ☐ DLI Diagnostic Laboratory Immunology
- ☐ DMP Dermatopathology
- ☐ DR Diagnostic Radiology

- ☐ EM Emergency Medicine
- ☐ END Endocrinology

- ☐ FOP Forensic Pathology
- ☐ FP Family Practice
- ☐ FPS Facial Plastic Surgery, Otolaryngology

- ☐ GE Gastroenterology
- ☐ GER Geriatrics
- ☐ GO Gynecological Oncology
- ☐ GP General Practice
- ☐ GPM General Preventive Medicine
- ☐ GS General Surgery
- ☐ GYN Gynecology

- ☐ HEM Hematology
- ☐ HNS Head & Neck Surgery
- ☐ HS Hand Surgery

- ☐ ID Infectious Diseases
- ☐ IG Immunology
- ☐ IM Internal Medicine
- ☐ IP Immunopathology

- ☐ LM Legal Medicine

- ☐ MFM Maternal & Fetal Medicine
- ☐ MFS Maxillofacial Surgery
- ☐ MM Medical Microbiology

- ☐ N Neurology
- ☐ NA Neuropathology
- ☐ NEP Nephrology
- ☐ NM Nuclear Medicine
- ☐ NPM Neonatal-perinatal Medicine
- ☐ NR Nuclear Radiology
- ☐ NS Neurological Surgery
- ☐ NTR Nutrition

- ☐ OBG Obstetrics & Gynecology
- ☐ OBS Obstetrics
- ☐ OM Occupational Medicine
- ☐ ON Oncology
- ☐ OPH Ophthalmology
- ☐ ORS Orthopaedic Surgery
- ☐ OS Other; *ie*, physician designated a specialty other than appearing here
- ☐ OTO Otolaryngology

- ☐ P Psychiatry
- ☐ PA Clinical Pharmacology
- ☐ PD Pediatrics
- ☐ PDA Pediatric Allergy
- ☐ PDC Pediatric Cardiology
- ☐ PDE Pediatric Endocrinology
- ☐ PDR Pediatric Radiology
- ☐ PDS Pediatric Surgery
- ☐ PH Public Health
- ☐ PHO Pediatric-Hematology-Oncology
- ☐ PM Physical Medicine & Rehabilitation
- ☐ PNP Pediatric Nephrology
- ☐ PS Plastic Surgery
- ☐ PTH Anatomic/Clinical Pathology
- ☐ PUD Pulmonary Diseases
- ☐ PYA Psychoanalysis

- ☐ R Radiology
- ☐ REN Reproductive Endocrinology
- ☐ RHU Rheumatology
- ☐ RIP Radioisotopic Radiology

- ☐ TR Therapeutic Radiology
- ☐ TRS Traumatic Surgery
- ☐ TS Thoracic Surgery

- ☐ U Urological Surgery

- ☐ VS Vascular Surgery

Approved specialty boards and certificate categories (effective March 1986) with codes.

American Board of	General Certificates		Subspecialty Certificates	
Allergy & Immunology	☐ AI	Allergy & Immunology	☐ DLI	Diagnostic Laboratory Immunology
Anesthesiology	☐ AN	Anesthesiology	☐ CCM	Critical Care Medicine
Colon & Rectal Surgery	☐ CRS	Colon & Rectal Surgery		
Dermatology	☐ D	Dermatology	☐ DMP ☐ DDI	Dermatopathology Dermatological Immunology / Diagnostic Laboratory Immunology
Emergency Medicine	☐ EM	Emergency Medicine		
Family Practice	☐ FP	Family Practice	☐ GER	Geriatric Medicine
Internal Medicine	☐ IM	Internal Medicine	☐ CD ☐ CCM ☐ DLI ☐ END ☐ GE ☐ GER ☐ HEM ☐ ID ☐ MO ☐ NEP ☐ PUD ☐ RHU	Cardiovascular Disease Critical Care Medicine Diagnostic Laboratory Immunology Endocrinology & Metabolism Gastroenterology Geriatric Medicine Hematology Infectious Disease Medical Oncology Nephrology Pulmonary Disease Rheumatology
Neurological Surgery	☐ NS	Neurological Surgery	☐ CCM	Critical Care Medicine
Nuclear Medicine	☐ NM	Nuclear Medicine	☐ NR ☐ RP	Nuclear Radiology (with ABRadiology) Radioisotopic Pathology (with ABPathology)
Obstetrics & Gynecology	☐ OBG	Obstetrics & Gynecology	☐ CCM ☐ GO ☐ MFM ☐ RE	Critical Care Medicine Gynecologic Oncology Maternal & Fetal Medicine Reproductive Endocrinology
Ophthalmology	☐ OPH	Ophthalmology		
Orthopaedic Surgery	☐ ORS	Orthopaedic Surgery	☐ HS	Hand Surgery
Otolaryngology	☐ OTO	Otolaryngology		
Pathology	☐ PTH ☐ ATP ☐ CLP	Anatomic & Clinical Pathology Anatomic Pathology Clinical Pathology	☐ BLB ☐ CP ☐ DMP ☐ FOP ☐ HEM ☐ IP ☐ MMB ☐ NA ☐ RP	Blood Banking Chemical Pathology Dermatopathology Forensic Pathology Hematology Immunopathology Medical Microbiology Neuropathology Radioisotopic Pathology
Pediatrics	☐ PD	Pediatrics	☐ DLI ☐ PDC ☐ CCM ☐ PDE ☐ PHO ☐ PNP ☐ PDP ☐ NPM	Diagnostic Laboratory Immunology Pediatric Cardiology Pediatric Critical Care Medicine Pediatric Endocrinology Pediatric Hematology-Oncology Pediatric Nephrology Pediatric Pulmonology Neonatal-Perinatal Medicine
Physical Medicine and Rehabilitation	☐ PM	Physical Medicine and Rehabilitation		
Plastic Surgery	☐ PS	Plastic Surgery	☐ HS	Hand Surgery
Preventive Medicine	☐ AM ☐ OM ☐ GPM	Aerospace Medicine Occupational Medicine Public Health & General Preventive Medicine		
Psychiatry and Neurology	☐ P ☐ N ☐ CHN	Psychiatry Neurology Neurology with Special Qualifications in Child Neurology	☐ CHP	Child Psychiatry
Radiology	☐ R ☐ DR ☐ TR ☐ RO ☐ RPH	Radiology Diagnostic Radiology Therapeutic Radiology Radiation Oncology Radiological Physics	☐ NR	Nuclear Radiology
Surgery	☐ GS	Surgery	☐ HS ☐ PDS ☐ SCC ☐ GVS	Hand Surgery Pediatric Surgery Surgical Critical Care General Vascular Surgery
Thoracic Surgery	☐ TS	Thoracic Surgery		
Urology	☐ U	Urology		

A

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GARY T MILLER MD
JOHN M MILLS MD
BERTRAM I MILSON MD
LOUIS MILSON MD
STUART E MILSON MD
ALI A MOHAMMAD-ZADEH MD
WAYNE S MOHR MD
GEETHA MURTHY MD
RICHARD L MYERS MD
GEORGE NADEAU MD
JAMES W NELLEN MD
HIRO NISHIOKA MD
CHARLES NORDELL MD
CLARENCE G NOVOTNY MD
MICHAEL J O'NEILL MD
MICHAEL D O'REILLY MD
EDWARD S ORMAN MD
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RICHARD C OUDENHOVEN MD
LESTER A OWENS DO
HOWARD J PALAY MD
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LOUIS D PHILIPP MD
SUSAN M PIECHOWSKI MD
CHRISTOPHER C PINN MD
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MICHAEL POREMBSKI MD
HENRY C RAHR MD
JOHN H RANDALL MD
JOHN J RANK MD
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WILLIAM M REYNDERS MD
BENSON L RICHARDSON MD
JAMES E ROBINSON MD
ROBERT J ROSE MD
DAVID L SAMUEL MD
DAVID P SAMUELS MD
HERBERT F SANDMIRE MD
KEVIN W SANDMIRE MD
RODNEY H SATHOFF MD
WILLIAM J SCHIBLY MD
JOHN C SCHIEBLER MD
SALLY M SCHLISE MD
FREDERIC W SCHMIDT MD
ROBERT T SCHMIDT MD
ROBERT T SCHMIDT JR MD
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JOHN P SCHUMACHER MD
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FREDERICK G SEHRING MD
RICHARD L SHAFFER MD
DANIEL W SHEA MD
DONALD L SHERWOOD MD
GOWDAR S SHIVAMURTHY MD
JOHN F SHRAKE MD
DONALD R SIPES MD
DARRELL P SKARPHOL MD
CHARLES C SMITH MD
MICHAEL J SMULLEN MD
JOHN R SOETER MD
STEPHEN V SOMERVILLE MD
HWE JAE SONG MD
ANATOL J STANKEVYCH MD
ROBERT J STEVENS MD
HAROLD E STINE MD
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ROGER H STRUBE MD
DONEL R SULLIVAN MD
JASWINDERJIT S SUNDLASS MD
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LOREN L THOMPSON MD
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GERALD R VERSTOPPEN MD
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MARY L WALBRIDGE MD
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ALAN F WENTWORTH MD
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WILLIAM J CARLSON MD
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N THOMAS CASPER
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KRISADA CHANBUSARAKUM MD
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TIMOTHY J CHYBOWSKI MD
MICHELLE L CIHLA
ELIZABETH L CIURLIK
PETER J CLAGNAZ MD
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CYNTHIA L CLINKINGBEARD MD
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MARCUS COHEN MD
R MARSHALL COLBURN JR MD
ROBERT L COLE MD
FREDERICK W COLEMAN MD
MICHAEL J COMBS MD
ELLEN B COMISKEY
PATRICK W CONNELLY MD
DEAN M CONNORS MD
DAVID U COOKSON MD
GARRETT A COOPER MD
JOSEPH E CORBETT JR MD
ROBERT J CORLISS MD
RICHARD D CORNWELL MD
ROBERT R CORNWELL MD
DAVID W CORY
DOUGLAS B COURSIN MD
BRIAN T COURTNEY MD
ARCH E COWLE MD
LAURENCE G CROCKER MD
EDWARD B CROWELL MD
WILLIAM P CROWLEY JR MD
ANDREW B CRUMMY JR MD
KENNETH B CUMMINGS MD
MILFRED A CUNNINGHAM MD
LUIS B CURET MD
MICHAEL J CURTIN MD
MARSHALL E CUSIC MD
A D'ALESSANDRO MD
JOHN P DALEY
ALFRED D DALLY MD
MICHAEL G DAMM MD
DANIEL DANAHY MD
JOHN H DANNER III
KRISHNA DASGUPTA MD
DONALD A DAUGHERTY MD
STEPHEN A DAUGHERTY
GORDON DAVENPORT JR MD
TRACY DAVID
PAUL L DAVIDSON MD
FREDERICK J DAVIS MD
JAMES E DAVIS MD
JEFFREY D DAVIS MD
JOHN B DAVIS MD
MATTHEW D DAVIS MD
WILLIAM F DAVIS MD
BETH DAYTON MD
ANTHONY J DE ANGELIS MD
DAVID G DE COCK MD
ALBERT J DEIBELE III
DOROTHY M DELISLE
JEAN DEMOPOULOS MD
SUSANA R K de DENNIS MD
JOHN T DENNY
GERALD J DERUS MD
ARTHUR A DE SMET MD
GUILLERMO B DEVENECIA MD
KENNETH DE VRIES MD
RICHARD T DE WITT MD
DAVID G DIBBELL MD
PHILLIP A DIBBLE MD
HELEN AIRD DICKIE MD
KLAUS D DIEM MD
DONALD G DIETER MD
CHARLES H DIGGS MD
WALDO B DIMOND MD
TIMOTHY J DOCTER MD
JULIE A DODDS MD
VERNON N DODSON MD
CHARLES A DOEHLERT MD
MARY L DOMBOVY MD
MARY K DOMINSKI MD
STEVEN J DONATELLO
WILLIAM F DONLIN MD
S THOMAS DONOVAN MD
TIMOTHY J DONOVAN MD
WILLIAM N DONOVAN MD
RICHARD K DORTZBACH MD
IVY J DREIZIN MD
MATTHEW M DREWRY
STEPHEN DUDIAK MD
PETER A DUEHR MD
FRANKLIN N DUKERSCHEIN MD
DOUGLAS A DULLI MD
JUNE M DURKEE
ROBERT E DURNIN MD
PAUL F DVORAK MD
PAUL R EBLING MD
DAVID E ECKERLE
DEVIN E ECKHOFF MD
LE ROY ECKLUND MD
ELIZABETH ECKSTROM
FREDERICK S EDELMAN MD
JOHN S EDWARDS MD
PETER L EICHMAN MD
DONALD M EILER MD
MARY K ELLIS MD
RICHARD L ELLIS MD
JOHN ENG
JAMES E ENGELER JR MD
C PETER ERSKINE MD
SCOTT A ESCHER MD
MARGARET A ESTRIN MD
JOSEPH J EVANS MD
WILLIAM S EVANS MD
ANNE R FABINY
DAVID K FALK MD
EUGENE S FARLEY JR MD
DENNIS JOHN FARNHAM MD
KENT FARNSWORTH
CAROLYN J FARRELL MD
ROBERT X FARRELL MD
DOUGLAS A FEHRMAN
THEODORE C FEIERABEND MD
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LUCILLE A FENDRICK
EDWIN E FERGUSON MD
FELIX J FERNANDES MD
ANDERS C FEX MD
REBECCA D FILLA
WILLIAM W FINCH MD
DAVID R FISHER MD
RAND I FISHLEDER MD
JAMES H FITZPATRICK JR MD
MARTIN B FLIEGEL MD
ELIZABETH A FORBES
CHARLES N FORD JR MD
FRANCIS M FORSTER MD
OSCAR F FOSEID MD
AMY M FOX
THOMAS D FRANCE MD
GREGORY A FRANCKEN
TERRENCE W FRANK MD
NANCY C FREDERICKS MD
RICHARD O FRIDAY MD
LISA C FRIEDMAN MD
JOHN G FROHNA
MICHAEL S FRONTIERA MD
NEIL P FULLAN MD
ERIC S GAENSLEN
ROBERT B GAGE MD
TIMOTEO L GALVEZ MD
JOHN S GANDOLFI MD
LEONARD J GANSER MD
JAMES P GAPINSKI
GORDON M GARNETT MD
JAMES G GARNETT MD
JEFFREY W GAVER MD
CHRISTOPHER A GENCHEFF DO
LINDELL R GENTRY MD
CHARLES H GEPPERT MD
AMY M GEROSO
CARL J GETTO MD
ROBERT D GILBERT MD
LAURENCE T GILES MD
MICHAEL D GILLUM MD
SUSAN L GOELZER MD
STEVEN P GOFF
FARRELL F GOLDEN MD
DAVID A GOODMAN MD
CHRISTAL A GORDON MD
ABRAHAM M GOTTLIEB MD
MARK F GOURLEY MD
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BEN K GRAF MD
RICHARD A GRAF MD
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TODD M GREATENS
JUDITH N GREEN MD
RAY E GREEN MD
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JAMES E GUTENBERGER MD
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SUSAN M HAACK MD
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DANIEL R HAGENGRUBER
DAVID L HAHN MD
DAVID A HALL
JUANITA J HALLS MD
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GEORGE H HANDY MD
GEORGE C HANK MD
MAREK J HANN MD
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MARC F HANSEN MD
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ROBERT C HARDIE MD
DONALD R HARKNESS MD
MARY N HARKNESS MD
LEWIS B HARNED MD
SAMUEL B HARPER MD
J TIMOTHY HARRINGTON JR MD
JAMES E HARRISON MD
TODD HART
THEODORE L HARTRIDGE MD
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DIANE G HEATLEY MD
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ANTHONY C HECHT
KAY A HEGGESTAD MD
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KIMBERLY B HEILPRIN
KELLI K HEINDEL
JOHN P HEINER III MD
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RICHARD J HENDRICKS MD
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ORIN A HERMUNDSTAD MD
RUSSELL J HERMUS
DOUGLAS E HERTFORD
PAUL A HERZOG MD
CYRIL M HETSKO MD
HUGO HIGA
MERIEL S HILL
NELS A HILL MD
RICHARD W HILL MD
MARVIN L HINKE MD
THOMAS J HIRSCH MD
CHARLES W HIRSCHLER MD
WILLIAM J HISGEN MD
PHILIP A HOFFMAN MD
KIRK HOGAN MD
JOHN M HOKANSON
BASIL B HOLOYDA MD
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ROY S HORRAS MD
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JEAN E HOYER
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D WILLIAM HURST MD
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MARK M HUYCKE MD
JAMES N ICKEN MD
PETER B IDSVOOG MD
LAURA B IMIG
CLAYTON L INGWELL MD
STANLEY L INHORN MD
G CONSTANZA IRIARTE MD
SUSAN N ISENSEE MD
GEORGE J ISHAM MD
KENNETH ISRAEL MD
SUZANA IVANOV
HAYTHAM M A JABI MD
C ROBERT JACKSON MD
LOIS J JACOBS MD
PAUL M JACOBSEN MD
WALTER H JAESCHKE MD
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SANJEEV JAIN
LESLIE C JAMESON MD
DON R JANICEK MD
DANIEL R JARZEMSKY MD
MANUCHER J JAVID MD
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PATRICIA A JENS MD
NORMAN M JENSEN MD
KAY E JEWELL MD
JANET B JOHANSSON MD
ELMER E JOHNSON MD
MILTON H JOHNSON JR
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TIMOTHY D JOHNSON MD
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J CHRISTOPHER KERR
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FRANK W KILPATRICK MD
LEROY K KIM
CHARLES K KINCAID MD
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PALMER R KUNDERT MD
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MICHAEL H MC DONALD MD
ROBERT A MC DONALD MD
ROBERT M MC GUCKEN
JAMES F MC INTOSH MD
CONSTANCE C MC KELVY
WILLIAM T MC KINNEY MD
PAUL A MC LEOD MD
WILLIS G MC MILLAN MD
EDWIN F MC NICHOLS MD
THOMAS D MEIER MD
WILLIAM E MEISEKOTHEN MD
FREDERICK A MELMS JR MD
JOHN T MENDENHALL MD
PHILIP D MERCADO
ALAN J MERKOW MD
ANTHONY L MERLIS MD
BARBARA J MERZ
THOMAS J MESCHER MD
EDWARD M MESSING MD
CHARLES T MEYER MD
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BERNARD F MICKE MD
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MARY M MILBRATH MD
CHARLES E MILEY III MD
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ELIZABETH A MOBERG
JON T MOEN MD
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STEPHEN M MOKROHISKY III MD
SHERI A MORRIS
MARRIOTT T MORRISON MD
LUTHER J MORTON DO
JOHN MOSES
HUBERT V MOSS JR MD
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MAUREEN A MUECKE
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CHARLES E NAHN MD
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CHRISTOPHER E NESEMANN
JAMES C NETTUM MD
CHARLES A NEUHAUSER MD
KATHRYN P NICHOL MD
WILLIAM R NIEDERMEIER MD
JULIE K NIELSEN
JOHN F NOON MD
EUGENE J NORDBY MD
VINCENT W NORDHOLM MD
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JERRY J NOREN MD
JAMES M NOSAL MD
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SANDRA M ORFGEN
SANDRA L OSBORN MD
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JOHN J OUELLETTE MD
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ROBERT M PASTER MD
JEFFREY J PATTERSON DO
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SHELDON M POLONSKY
FRANK P POLYAK MD
PETER M POPIC MD
ATHENA POPPAS
JAMES F PORTER MD
EDWARD M PORTMAN MD
LUCILLE J POULIN MD
MYRON A POZNIAK MD
ROBERT B PREHN
EDWARD J PRENDERGAST MD
GEOFFREY R PRIEST MD
MARGARET J PROUTY MD
KARVER L PUESTOW MD
THOMAS R PUETZ
DAVID W QUEOFF
ABRAHAM A QUISLING MD
SVERRE QUISLING MD
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MARK REICHELDERFER MD
SCOT C REMICK MD
JULIA K RESCHKE MD
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MARK J RICE MD
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KURT M RONGSTAD
JAMES W ROSE JR MD
MELVIN H ROSEN MD
HARRY ROTH MD
LAURENCE ROTHSTEIN MD
ROYAL ROTTER MD
WAYNE M ROUNDS MD

JEFFREY K ROWE MD
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MARCIA J SLATTERY
VERA SLAVIC-SVIRCEV MD
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MAX M SMITH MD
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RICKEY L SNIPES
STEPHEN N SNOW MD
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ALBERT L WILEY JR MD
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JAMES M WILKIE MD
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MARGARET C WINSTON MD
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JOHN T WITTE MD
RICHARD C WIXSON MD
WILLIAM H WOLBERG MD
CHRIS WONG
HUMPHREY WONG
LORNA J WONG
WILLIAM A WOOD MD
JOHN E WOODFORD MD
GARY WOROCH MD
STANLEY F WYNER MD
MARTHA M WYNN MD
MICHAEL R YAFFE MD
CHARLES E YALE MD
DENNIS T YAMAMOTO MD
DEAN A YEAGER
ROY V YEAZEL MD
WILLIAM H YLITALO MD
WILLIAM P YOUNG MD
KOK-PENG YU MD
NAMDAR ZARVAN
RONALD A ZEROFSKY MD
JOHN J ZIEBERT
JOSEPH D ZIRNESKIE MD
MARY L ZUPANC MD

DODGE

M AHMAD ALI MD
MICHAEL K AUGUSTSON MD
MICHAEL W BACHHUBER MD
RAFAEL BARAJAS MD
JACK R BARTHOLMAI MD
ROGER I BENDER MD
JAMES S BERRY MD
ROBERT F BOOCK MD
CURTIS W BUSH MD
VICTOR W CACERES MD
CRAIG W CAMPBELL MD
EDWARD F CODY MD
R SANFORD COOK MD
DOWE P CUPERY MD
STANLEY G CUPERY MD
RICHARD A DAMON MD
GEORGE E DAVIS MD
RENATO C DIANCIN MD
GEORGE G DRESCHER MD
ALAN A EHRHARDT MD
DANIEL R ERICKSON MD
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WILLIAM J PETTERS MD
STEVEN J RAWLINS MD
TIMOTHY J RENTMEESTER MD
WILLIAM G RICHARDS MD
THEODORE ROWAN MD
AYAZ M SAMADANI MD
NORMAN H SCHULZ MD
JOHN A SMITH MD
WILLIAM H SNOOK MD
JOHN F SULLIVAN MD
JOHN A SZWEDA MD
PETER W TIMMERMANS MD
HER-LANG TU MD
MARIO C VILLEGAS MD
ANDREW P VRABEC MD
KI JUN WHANG MD
EDWARD B WOHLWEND MD

DOOR-KEWAUNEE

VALENTINO S ANCHETA MD
JOHN J BECK MD
THOMAS C BOYD MD
JEFFREY J BROOK MD
DAVID G CONGER MD
ROLAND G EVENSON MD
WILLIAM FALLER MD
FRANCIS GILBERT MD
JOHN L HERLACHE MD
WALTER S HOBSON MD
R SCOTT LIEBL MD
JACK F MARCH MD
EDWARD P MC AULIFFE MD
MICHAEL R MC FADDEN MD
JAMES P MC GUIRE MD
WILLIAM G MEYER MD
RICHARD C MURRAY MD
REYNOLD M NESEMANN MD
KEVIN M O'BRIEN MD
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DONALD J RYAN MD
BARBARA A SANDEFUR MD
WELDON G SHEETS MD
THOMAS M STEED MD
ALFONSO G TAMAYO MD
JOHN W TAYLOR DO
JOAN A TRAVER MD
BRIAN D WAKE MD
JOAN P WAKE MD
MARK O WEISSE MD
ERIE W WITS MD
THOMAS M ZENNER MD

DOUGLAS

MOHAMED W AL-AZEM MD
THOMAS J DOYLE MD
JON F FRANCO MD
RICHARD E FREEMAN MD
RICHARD P FRUEHAUF MD
JOSEPH B FULLER MD
LAWRENCE J JAEGER MD
FRED G JOHNSON JR MD
GENE G KARWOSKI MD
JOHN A KNIGHTS MD
JULIANNE E KOSKI MD
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ANTONIO L LAO MD
ISRAEL H LAVINE MD
ROBERT R MATACZYNSKI MD
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DOUGLAS R MEYER MD
KONANUR G RAMESH MD
JAMES A ROBERTS MD
ANN M ROCK MD
ROBERT L SELLERS MD
EDWARD G STACK JR MD
JON C STEPHENSON MD
BRIAN C SWANSON MD

EAU CLAIRE-DUNN-PEPIN

STEVEN C ADAMSON MD
HERBERT M AITKEN MD
RICHARD P ALFUTH MD
IRFANE M AL-KHATIB MD
GREGORY J ANDERSON MD
ALAN W BABCOCK MD
LARRY J BARTHEL MD
PATRICK J BATES MD
JONATHAN L BAYBA MD
BRUCE C BAYLEY MD
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TERRANCE R BORMAN MD
JAMES V BOUNDS JR MD
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GARY P BRANDELAND MD
EDWARD R BROUSSEAU MD
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RICHARD J BRYANT MD
SARAH K BURGESS MD
ROBERT BURGFECHTEL MD
W GRAHAM CAMERON MD
RANDALL J CASPER MD
DAVID P CATTAU MD
DANIEL G CAVANAUGH MD
JOHN M CHANNER MD
DANIEL M CLARK III MD
JANICE CLARKE MD
RICHARD N COCHRANE MD
TIMOTHY J CROSS MD
CLAUDE D DAVIS MD
WILLIAM F DECESARE MD
EDWARD M DENNISON MD
MARK E DEYO-SVENDSEN MD
MICHAEL R DIESTELMEIER MD
C THOMAS DOW MD
THOMAS J DOYLE JR MD
ROBERT A DURST JR MD
MARK E EDSTROM MD
DAVID EITRHEIM MD

GENE G ENDERS MD
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MAURO J AGNELNERI JR MD
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NONITO M SABLAY MD
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DONALD F VAN BEEK MD
KIRK A VEIT MD
EDWARD W VETTER MD
ROBERT L WAFFLE MD
HONG CHU WANG MD
DAVID R WEBER MD
JOHN A WELSCH MD
FREDERICK C YUHAS MD
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FOREST

E FRANK CASTALDO MD
BURTON S RATHERT MD

GRANT

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KENNETH L BAUMAN MD
LEO E BECHER MD
ANN R BERLAGE MD
JOHN J DAVID MD
MARTIN E FARBSTEIN MD
WILLIAM P FAST MD
SCOTT M GREEN MD
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ERIC K ANDERSON MD
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EDWIN L OVERHOLT MD
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PAUL W PHILLIPS MD
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ABBAS RAHIMI MD
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JAMES D RICHARDSON MD
CAMERON F ROBERTS MD
DENNIS K RYAN MD
EDWARD G RYDELL DO
VIJAY K SABNIS MD
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KARL H STAHMER MD
IVAN STANKO MD
THOMAS A STARKEY MD
STEVEN C STODDARD MD
ROGER A STYLES MD
RAYMOND J SZMANDA DO
DAVID B TANGE MD
GEORGE R TANNER MD
GEOFFREY TAYLOR MD
JUDITH E WADE MD
ARTHUR M WALDMAN MD
ROBERT J WARE MD
JOHN F WEBB MD
DENNIS W WESTERN MD
DARRELL L WITT MD
GEORGE J WITTEMAN MD
LEONARD H WURMAN MD
EARL W ZABEL MD
PHILIP M ZICKERMAN MD
GARY A ZIMBRIC MD

MARINETTE-FLORENCE

ANTOINE BARRETTE MD
NEIL C BINKLEY MD
CLARK H BOREN MD
JAMES A BOREN MD
JOHN P BRIODY MD
VERNETTE M CARLSON MD
STEPHEN C CASELTON MD
SHERWOOD A COLE MD
DAVID D DARCY MD
JACKSON T DEMPSEY MD
GERALD W FAVRET MD
J BRYAN FLYNN MD
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STEVEN H HOYME MD
THOMAS J KNUTSON MD
CHARLES E KOEPP MD
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ALICE M LEE MD
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THOMAS V MACK MD
DEAN A MAGNIN MD
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FREDERICK SOBIERAY DO
BURNELL D STRIPLING MD
JAMES TANDIAS MD
JUNG-NAN TSAI MD
HENRY VEIT MD
LEONARD R WORDEN MD
KENNETH H YUSKA MD

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WADIE A ABDALLAH MD
SANDRA L ABLER
JULIAN E ABRAMS MD
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JOSEPH J ADAMKIEWICZ JR MD
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JOSE R AGONCILLO JR MD
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KEITH M AL ATASSI MD
DONALD J ALBRECHT MD
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LARKIN N ALLEN DO
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CHARLES H ALTSHULER MD
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SENEN S ARCILLA MD
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SARA ARNOLD MD
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STUART M COOPER MD
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KATHERINE L COPPS
JOHN E CORDES MD
VICTOR J CORDES MD
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ROBERT P CRONIN MD
MAXIMO L CUETO JR MD
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HARRY M CUTTING MD
JOHN J CZAJKA MD
RUSSELL C DABROWSKI MD
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R CLARKE DANFORTH MD
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EINAR R DANIELS MD
STEVEN K DANKLE MD
CAROL L DANNING
LEWIS DANZIGER MD
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RICHARD D DAVENPORT MD
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FRANK L DE GROAT JR MD
THOMAS G DEHN MD
THOMAS A DE HOOP
ALFONSO B DEIPARINE JR MD
FRANCISCO Y DEL MAR MD
MARTIN J DENIO JR MD
STEPHEN T DENKER MD
ARLEN D DENNY MD
ALBERT DE ROSE MD
ARTHUR R DERSE JD MD
JEFFREY A DERUS MD
BERTRAM H DESSEL MD
JEANMARIE P DEUSTER MD
ANTHONY W DEUSTER
MARION L DE VAULT MD
BARBARA DEWITZ MD
ALI A DIBA MD
FREDERICK T DICKINSON DO
WILLIAM T DICUS MD
MICHAEL A DIDION DO
KATHERINE M DILLIG MD
PETER DIONISOPOULOS
ROBERT A DI ULIO MD
JOHN P DOCKTOR, DDS MD
JAMES D DOLAN MD
JEFFREY M DOMNITZ MD
PARNELL DONAHUE MD
DANIEL J DONOVAN DO
JOHN E DOOLEY MD
JEFFREY M DORF MD
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DAVID K DORMAN MD
ANTON S DORN MD
ARTHUR J DORRINGTON MD
PATRICK A DOWLING
GRACE DOWNING MD
MICHAEL P DOYLE
WILLIAM G DRALLE MD
CHRISTOPHER J DRAYNA MD
DONALD A DREW
HILBERT N DRICKEN MD
JOSEPH M DRINKA MD
THOMAS P DRISCOLL MD
ELAINE C DROBNY MD
MAX F DROZEWSKI MD
EMIL J DRVARIC MD
LAWRENCE M DUBIN MD
ELIZABETH A DUBINA MD
RICHARD A DUCHELLE MD
PAUL A DUDENHOEFER MD
LARRY L DUENK
T KEITH DUNCAN MD
THOMAS H DUNIGAN MD
DAVID K DUNN MD
CARL G DUNST MD
EUGENE C DURKIN MD
GRETCHEN E DURKIN MD
EDMUND H DUTHIE JR MD
FRANCINE L DVORACEK MD
RAY R DZELZKALNS MD
PAULINE M EARLE MD
HARRY A EASOM MD
PHILIP T ECKSTROM MD
MARK EDENS
HASSAN EGHBALI MD
JOCELYN K EICHE MD
CHARLES R EICHENBERGER MD
CARL S L EISENBERG MD
EDWARD EISENBERG MD
DARRYL L EISENBERGER DO
REUBEN EISENSTEIN MD
GREGORY A EKBOM MD
RAKKI G ELANGOVAN MD
ARNOLD N ELCONIN MD
SAM GUS ELEFTHERIOU MD
SHARON L ELIAS MD
JOHN G ELLIS MD
MARK A ELSON MD
MATTHEW W ELSON MD
JACK A END MD
CHARLES J ENGEL MD
JOHN ERBES MD
CHESLEY P ERWIN MD
JOHN H ESSER MD
WILLIAM R ESSER DO
JAMES E ETHINGTON MD
CHRISTOPHER J EVANICH
RICHARD N EVANS JR MD
KENNETH S FABRIC MD
JOHN J FAHEY MD
NORBERT J FAHEY JR MD
JULIAN W FALECKI MD
FRANK P FALSETTI MD
GEORGE E FARLEY MD
HUBERT J FARRELL MD
MICHAEL R FEHRER MD
LEWIS M FEIGES MD
ADAM F FEINGOLD
DONALD L FEINSILVER MD
SCOTT R FELDY DO
RENATO C FELIZMENA MD
GREGORY A FELSHEIM MD
MARY C FERNANDEZ MD
JOHN P FETHERSTON JR MD
MICHAEL P FETHERSTON MD
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HOWARD W FIEDLER MD
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LLOYD L FIFRICK MD
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JACOB M FINE MD
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CHARLES J FINN MD
DONALD C FISCHER MD
J ROBERT FLAMINI MD
CASEY J FLANARY MD
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SHARON A FLEISCHFRESSER MD
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JEROME W FONS JR MD
PETER S FOOTE MD
DANIEL J FORWARD MD
CURTIS W FOWLER MD
MEYER S FOX MD
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NANCY K FRANCE MD
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JAMES W FULTON MD
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REYNALDO P GABRIEL MD
FREDERICK G GAENSLEN MD
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DANIEL J GEENEN
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MARY J GEIGER
NICHOLAS F GEIMER MD
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CARL G HORSTMEYER
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JOHN T HOTTER MD
TIMOTHY S HOUDEN
MARY ALICE HOUGHTON MD
WILLIAM HOUGHTON MD
EVERIN C HOUKOM MD
JEROME W HOUSE JR MD
WILLIAM F HOVIS JR MD
LAWRENCE A HOWARDS MD
JACQUELINE COATES HOWELL MD
SUPING J HSIEH MD
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STEPHEN M HUEBLER
DANIEL HUFF MD
MARK A HUFFMAN MD
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GEORGE R HUGHES MD
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BERNARD A HUIZENGA MD
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SALLY G HUNT MD
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RITA F HUSPEN
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BENJAMIN W LYNE MD
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DANIEL J MC CARTY MD
THOMAS F MC CORMICK MD
SAMUEL R MC CREADIE MD
TIMOTHY L MC CULLOUGH
WILLIAM P MC DANIEL MD
JAMES F MC DERMOTT MD
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JANICE G MC FARLAND MD
TIMOTHY A MC GILLIVRAY
BARBARA J MC GRATH
SCOTT T MC GRAW
EDWARD J MC GUINNIS MD
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RICHARD A MC KAY JR MD
NORVAL W MC KITTRICK MD
MARY P MC NAMARA MD
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DANIEL P MC QUILLEN MD
BRIAN P MC SORLEY MD
PATRICK J MC WEY MD
JAMES A MEANS III MD
PETER M MEDVED MD
MARK A MEIER MD
MORRIS M MEISTER MD
ABDALLAH G MELKONIAN MD

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JAMES E MINIKEL MD
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RICHARD E MINKLEY MD
DANIEL J MIOTA DO
MAHMOOD MIRHOSEINI MD
MARSHAL J MIRVISS MD
DAVID A MISORSKI
SURESH K MISRA MD
LEROY MITCHAM MD
SAMIR K MITRA MD
RAM K MITTAL MD
WALTER L MODAFF MD
RITA D MODY MD
MORRIS MOEL MD
BRIAN K MOLONEY
HERMES E MONATO MD
ANGELINA M MONTEMURRO MD
JOSE V MONTENEGRO III MD
ARTEMIO M MONTES MD
ROBERT G MONTGOMERY MD
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M KELLOGG MOOKERJEE MD
GEORGE E MOORE MD
J STEVEN MOORE MD
ROLAND MORE
JOSE M MORENO MD
LUZ S MORENO MD
LLOYD W MOREY DO
MARY S MORRIS MD
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DAVID S NASH MD
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DENIS C NATHAN MD
PAUL A NAUSIEDA MD
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LONZETTA NEAL
JAMES R NELLEN MD
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SAM P NESEMANN MD
MARY E NESS MD
MARGARET NEWTON MD
SON N NGUYEN MD
GREGORY M NIERENGARTEN DO
ROBERT A NIMZ MD
GILBERT J NOCK JR MD
PATRICK J NOONAN MD
ARTHUR G NORRIS MD
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JOSEPH P NOTHUM MD
ARMANDO N NUNAG MD
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HAROLD H OBERFELD MD
JAMES R O'CONNELL MD
MARY C O'CONNOR MD
THOMAS A O'CONNOR MD
THOMAS M O'CONNOR MD
HERBERT W OECHLER MD
MICHAEL G O'GRADY MD
KENNETH W OLANDER, PhD MD
VIGGO B OLSEN MD
CARL E OLSON MD
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JAYA C PRASAD MD
GARY L PREISLER DO
DANIEL J PRICE MD
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PAUL HAROLD REHNSTROM DO
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DONALD K SHAW MD
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HEATHER A SHELTON
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SHAILA R SHIRKE MD
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NARINDER K SIDHU MD
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STEPHEN G SIEVERS MD
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TED S SILVER MD
GEORGE W SIMONS III MD
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VIOLETA A SINGSON MD
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PERFECTO COMPETENTE MD
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THOMAS W LUTHER MD
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Created by the Territorial Legislature in 1841 and now representing nearly 7,000 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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Physicians Exchange

Minnesota, Iowa, and Wisconsin group practice positions are available for BE/BC physicians in the following specialties: Family Practice, Adult/Child Psychiatry, Internal Medicine, Occupational Medicine, Pediatrics, and Obstetrics/Gynecology. Competitive salary with benefits. Send letter of inquiry and curriculum vitae to Scott M. Lindblom, Fairview Clinic Services, 2312 South 6th St, Minneapolis, MN 55454 or call 612-371-6235 or toll-free 1-800-328-4661, ext 6235. An equal opportunity employer. p8-9/88

Five-member Cardiology Group seeking BE/BC associate with invasive/non-invasive capabilities. Medical referral center for northeastern and east central Wisconsin. Liberal guarantee/benefit arrangements. Full partnership available. Send CV or call: Dr James Cole, Appleton Cardiology Associates SC, 820 East Grant St, Appleton, WI 54911; 414-731-8900. p8-10/88

Anesthesiology, Dermatology, Family Medicine, General Surgery, Internal Medicine, Orthopedics, Otolaryngology, OB/GYN, Pediatrics, Psychiatry. ALRMG is a 37-MD non-HMO clinic in beautiful Albert Lea, Minn. These positions are created by retirements and development of new departments. The hospital and clinic are modern, progressive, established and the primary health care providers in our service area. Excellent educational and cultural opportunities. Competitive income, excellent benefits, early shareholder status with first year salary guarantee with incentive options. Send CV to Administrator, ALRMG, 1602 Fountain St, Albert Lea, MN 56007-1642 or call 507-373-8251 for further information. p8-10/88

RATES: 50¢ per word, with a minimum charge of $20.00 per ad. BOXED AD RATES: $25.00 per column inch. *All ads must be prepaid.*

DEADLINE: Copy must be received by the 1st of the month preceding month of issue; *eg,* copy for the August issue is due July 1. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free in Wisconsin: 1-800-362-9080.

Family Practice. Marshfield Clinic is seeking BE/BC family practitioners to join its expanding department in Marshfield. The department is currently staffed by five family practitioners with plans to add three additional members. With the exception of obstetrics, which is done by staff obstetricians, the practice offers a full range of inpatient and outpatient services. Full specialty consultation is readily available in-house. Our community of 20,000 offers strong economic stability combined with exceptional recreational, cultural, and educational opportunities. We offer a current starting salary up to $85,000 with salary in two years up to $110,000. Fringe benefit package outstanding. Send CV and references to David L. Draves, Department of Administration, 1000 North Oak Ave, Marshfield, WI 54449 or call collect 715-387-5376. 8/88

Orthopedic Surgeon Board-certified/eligible to join a 24-physician multispecialty group in Winona, Minnesota. Total patient population draw area of 40,000. Interested physicians please contact: Jerome B. Knuesel, Administrator, Winona Clinic, Ltd, 420 East Sarnia, Winona, MN 55987. 8-10/88

Career opportunity for qualified Emergency Room physician. Our group covers two hospital emergency rooms and an active walk-in clinic in southeastern Wisconsin. Full fringe benefit package and flexible scheduling offered. Interested parties contact John W. Linstroth, MD, 1201 Sherwood Lane, Caledonia, WI 53108; ph 414-835-7761. 8tfn/88

General Internist/Endocrinologist, Cardiologist / Rheumatologist, BE, Board-certified to join a 16-man internal medicine department in a dynamic growing multispecialty clinic. Attractive salary with a full range of benefits. Mid-size midwestern community with excellent educational, recreational, social activities. Please send CVs and references to: Ross A. Madden, MD, Medical Director, Medical Associates Clinic, PC, 1000 Langworthy, Dubuque, IA 52001. 8-10/88

Invasive Cardiologist. Monroe Clinic near Madison, 54-physician group seeks third cardiologist. 270-bed hospital, new cath lab, attractive salary, benefits. Contact Dept 620 in care of the Journal. p8-10/88

Internal Medicine. Doctors Clinic, Two Rivers, Wisconsin. Eight-physician group seeks second internist, critical care interest beneficial, three area hospitals. Contact Dept 621 in care of the Journal. p8-10/88

Due to retirement, we are seeking a third general surgeon for the surgical department of a 55-member multispecialty clinic in Janesville, Wisconsin. The clinic is on the grounds of a modern and well-equipped hospital with three outlying primary care satellites in neighboring communities. Janesville, Wisconsin, is a city of 51,000 people centrally located between Madison and Milwaukee, Wisconsin, and Chicago, Illinois. Vascular experience is necessary. Excellent benefits are provided. Salary for the first year and then full partnership. If interested, send curriculum vitae to Ronald P. Karzel, MD, Janesville Riverview Clinic, 580 N Washington St, Janesville, WI 53545. 8-10/88

General and Vascular Surgeon, university trained, sought as ambitious associate for very busy surgeon. Rewarding, hard work in sophisticated medical community. Robert Mikkelsen, MD, FACS, 14 N Main St, Fond du Lac, WI 54935. p8;9-11tfn/88

Family Practitioner. Excellent opportunity to associate with a successful group practice. Young, five-member group is seeking a Board-certified or eligible family practitioner to replace one member leaving the area. Salary guarantee, ownership opportunity in one year. Clinic is adjacent to 40-bed JCAH accredited hospital. Community located in scenic four season recreation area within easy driving of large population centers. Send CV and references to Michael Nelli, Manager, Cumberland Clinic, PO Box 127, Cumberland, WI 54829. p8-9/88

Full-time Medical Director to head newly expanded physicians health and effectiveness program. The position may be filled as early as September 1988. Basic requirements are Degree of Doctor of Medicine, licensed to practice medicine in North Carolina prior to employment, good health, successful administrative experience, demonstrable communications skills, demonstrable knowledge in addictionology, strong, verifiable recovery, if applicable. Letter of application, accompanied by detailed curriculum vitae, should be addressed to: Medical Director Search, North Carolina Medical Society, PO Box 27167, Raleigh, NC 27611. g8/88

Family Practice, Brainerd, Minnesota. Immediate opening for seventh BC/BE FP for 18 multispecialty clinic. No capitation. Two hours from Minneapolis. Beautiful lakes and trees, ideal for families. Call collect/write Curtis J. Nielsen, (218) 829-0354 or 4901. PO Box 524, Brainerd, MN 56401. 6-8/88

Physicians Exchange

continued

Primary Care. Primary care physician to work in "Walk-In" Department of busy and expanding multispecialty group. Twelve to fifteen hours per week. Excellent back-up services. Contact: Administrator, Rice Clinic, 2501 Main St, Stevens Point, WI 54481 or call collect 715-344-4120. 8tfn/88

Family Practice physician wanted to be associated with branch clinic of a large multispecialty group. Opportunity for family practice in Prairie du Chien, Whitehall, Viroqua or Tomah, Wisconsin; West Union, Iowa. Physician would be associated with a multispecialty group. Relief provided for vacations, meetings, etc. Educational opportunities through an excellent education program. Beautiful countryside, cultural, and recreational facilities. Excellent fringe benefits. Salary commensurate with background and experience. Write or call: Tim Skinner, MSEd, Family Practice Representative, Gundersen Clinic, Ltd, 1836 South Ave, La Crosse, WI 54601. 8/88

Family Practice (BC/BE) opportunity to join a five-physician family practice group in south central Wisconsin city of 15,000. Pleasant community atmosphere within 1–1½ hours of Madison and Milwaukee. Excellent recreational area. First year guaranteed salary. Contact: Chad Burchardt, Business Manager, Medical Associates of Beaver Dam, SC, 1200 N Center St, Beaver Dam, WI 53916; ph (414) 887-7101. p6-8/88

ORTHOPEDIC SURGEON
NEUROSURGEON
PHYSIATRIST
Industrial Rehabilitation

Outpatient orthopedic clinic seeking additional physicians to join growing industrial rehabilitation center specializing in disability evaluation, treatment, medical management, functional capacity assessment, work-hardening programming and employer consultation services. Part-time and full-time opportunities. Excellent guaranteed salary with incentives plus excellent fringe benefits. Please send CV to:

Bone & Joint Surgery Associates
Chiron Rehabilitation Clinic
2704 Marshall Court
Madison, Wisconsin 53705
(608) 231-3030

7-9/88

Iowa-Decorah, located in northeastern Iowa, near the Minnesota, Wisconsin borders, is seeking a BE/BC psychiatrist. The opportunity exists to establish a solo practice with plans of adding an additional psychiatrist within a year. Brand new psychiatrist unit to be completed shortly. Located 70 miles outside of Rochester, Minnesota, and 60 miles from La Crosse, Wisconsin, Decorah, home of Luther College, covers a six-county area with a service population in excess of 125,000. Excellent guarantee with benefits, additional compensation through the CMHC for contractural services. **Wisconsin**—Scenic lake country. St Mary's in Rhinelander, Wisconsin, is seeking a BE/BC second psychiatrist. General adult psychiatrist with subspecialty interests in child/adolescent preferred. St Mary's is a 150-bed facility with a 20-bed psychiatric unit. Complete psychiatric medical staff. Excellent guarantee with benefits. **Wisconsin-Reedsburg,** 50 miles outside of Madison, is seeking a third adult psychiatrist. The incoming psychiatrist may establish a private practice with the two current psychiatrists in the community or choose to establish an association with the Madison Psychiatric Associates. Excellent guarantee with benefits. Contact: Jean Ecos, 15975 W National Ave, New Berlin, WI 53151; ph (414) 784-2777 (collect). 7-8/88

The Wausau Medical Center is seeking BC/BE individuals in the following specialties: Cardiology, Dermatology, Family Practice, Infectious Disease, Obstetrics/Gynecology, Pediatrics and Rheumatology. Modern clinic facility located across the street from modern 300-bed hospital. Full partnership in three years. Easy access to lakes, woods and mountains. Write including CV to D.K. Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, WI 54401. p4tfn/88

Internal Medicine. Board-certified or eligible to join five general internists in a multispecialty group in northeastern Wisconsin. Office is next to two hospitals. Partnership is available after one year. Send CV to Dept 613 in care of the Journal. p4-9/88

NEW PHYSICIANS
FOR WISCONSIN
is seeking
• Family Physicians • Pediatricians
• Orthopedic Surgeons • Internists
Contact: Fred Moskol
UW Office of Rural Health
810 University Bay Drive
Madison, WI 53705
608/263-7933

7-12/88;1-6/89

Wisconsin. OB/GYN (BC/BE) needed to join dynamic HMO-based multispecialty group practice. University town of 55,000 near Minneapolis. Community and recreation outstanding. Competitive salary and fringes. We take pride in our patient care. Contact Robert A. Braastad, MD, Group Health Cooperative, 1030 Regis Court, Eau Claire, WI 54701; ph 715-836-8552. p5/88;6-9/88

West Bend, Wisconsin, General Clinic, a 20-physician multispecialty group is seeking additional B/C, B/E physicians in **Family Practice, Pediatrics, OB/GYN, Internal Medicine, Urology, Dermatology,** and **ENT.** First-year salary and benefits guaranteed. Corporate association after one year. Located in a family-oriented, economically strong small city surrounded by four-season recreational and scenic Kettle Moraine area 30 miles north of metropolitan Milwaukee. Contact Hans W. Schmelzling, Administrator, 279 S 17th Ave, West Bend, WI 53095; ph 414/338-1123. 7tfn/87

Family Practitioner to join a progressive 12-physician practice at its Ellsworth, Wisconsin branch. Rural community 40 miles from St Paul, Minn. Liberal benefit package. Salary commensurate with background and experience. Contact R.M. Hammer, MD, River Falls, WI 54022; ph (715) 425-6701 or (612) 436-8809. 7tfn/88

Physicians to take in-house call. Ideal position for residents and moonlighting physicians. Second-year residents may be suitable. Call Donna, (815) 395-5187 or write ETC, Ltd, PO Box 8034, Rockford, IL 61125. 6-8/88

Internist with or without subspecialty interests. Board-certified or eligible to join a well-established nine man expanding multispecialty group. Location is in a southeastern Wisconsin city of 36,000 with access to a large inland lake, initial salary plus percentage as an associate. Full status in-service corporation with shared overhead and an incentive orientated formula after the first year. Please contact E.T. Ayala, MD, Department of Internal Medicine, Sharpe Clinic, SC, 92 East Division St, Fond du Lac, WI 54935; ph (414) 921-0560, collect. p6-11/88

Eagle River—Great opportunity for two BC/BE family practice physicians to join well-established practice. Guaranteed annual income and future partnership available. For more information, send resume to Judy Harris, Recruiter, UW Office of Rural Health, 810 University Bay Dr, Madison, WI 53705 or call collect 608/263-7933. 1tfn/88

Emergency Medicine, Brainerd, Minnesota. Need BC/BE EM or FP. Join a BC/EM MD and 18 MD multispecialty clinic. Two hours from Minneapolis. Beautiful lakes and trees, ideal for families. Call collect/write Curtis J. Nielsen (218) 829-0354 or 4901. PO Box 524, Brainerd, MN 56401. 6–8/88

Family Practice partnership, Chilton, Wis, (near Sheboygan, Appleton, Fond du Lac). Ultra-modern and urban-designated hospital. Rapidly expanding practice with limited call schedule. Merely ask for informational mailing by contacting Joe Schumacher. Write Calumet Medical Center, Chilton, WI 53014; ph (414) 849-2386. p6–8/88

BC/BE General Internist to join 26-MD multispecialty group with four internists, one nephrologist and one gastroenterologist. Top salary first year, full incentive thereafter. Central Wisconsin university town with drawing area of 80,000. Send CV to Dr John Gauder, Rice Clinic, SC, 2501 Main St, Stevens Point, WI 54481, or call collect 715/344-4120. 12tfn/87

Twenty-nine physician multispecialty clinic located in desirable East Central Wisconsin location is seeking Board-certified or Board-qualified orthopedic surgeon to round out its services. Lab, x-ray, excellent hospital. Liberal guarantee and benefits. If interested contact D.F. Sweet, MD, Fond du Lac Clinic, SC, 80 Sheboygan St, Fond du Lac, WI 54935. 9tfn/87

Immediate opening. One internist to head the Medical Services at a 250-bed acute treatment psychiatric hospital, JCAH approved, Medicare certified, affiliated with the University of Iowa Medical College. Forty-hour work week. No night or weekend on call. Situated in picturesque northeast Iowa near large cities with cultural advantages. Ideal for family living. Golf club, hunting and fishing area, good schools, etc. Salary to $81,012. State law protects employees against malpractice. State pension plan. Unique deferred annuity plan. Generous sick leave and vacation. Write or call collect B.J. Dave, MD, Superintendent, Mental Health Institute, Independence, IA 50644; ph (319) 334-2583. An Equal Opportunity/Affirmative Action Employer. 7–8/88

Emergency Medicine, Otolaryngologist, Urologist, and Obstetrician/Gynecologist to join multispecialty group practice in Woodruff, WI. Guaranteed annual income and excellent fringe benefit program. Send CV to R.J. Sloan, MD, Lakeland Medical Associates, Ltd, PO Box 549, Woodruff, WI 54568. 4tfn/88

Physicians needed immediately. ER experience necessary. To cover weekend shifts. Location—Northeastern Wisconsin. Professional liability can be provided. Competitive rates. Call 414-647-0976 and/or send CV to WUEMS, PO Box 15362, Milwaukee, WI 53215-5362. p8/88

Psychiatrist/Chemical Dependency. Psychiatrist interested in chemical dependency needed to join 220-physician multispecialty group with adjacent 447-bed hospital. Position includes inpatient services of Chemical Dependency Unit with full range of outpatient chemical dependency services available, Evaluation and Detoxification Unit, outpatient chemical dependency clientele and followup, general psychiatric practice also available; Behavioral Medicine Department is presently staffed by seven psychiatrists, one child/adolescent psychiatrist and two psychologists. New clinic building recently completed. Gundersen Clinic, Ltd, is located in La Crosse, Wisconsin, a progressive community of 50,000. Built along the shores of the Mississippi River amid scenic bluffs, the city offers excellent recreational facilities. Numerous educational and cultural opportunities are provided by an expanding university with undergraduate and graduate degree programs, and a private liberal arts college. Excellent pension program, no investment required. Service organization. Write Philip J. Dahlberg, MD, Chairman, Personnel Committee, Gundersen Clinic, Ltd, 1836 South Ave, La Crosse, WI 54601. An Equal Opportunity Employer. 8/88

Family Practice—Madison, Wisconsin. Eleven-year-old staff model HMO has a family practice position available. We offer a very attractive practice setting with reasonable scheduling, excellent salary, and benefits. Contact John Hansen, MD, Medical Director, Group Health Cooperative, One South Park, Madison, WI 53715; ph (608) 257-9700. 7–9/88

Physicians needed full- or part-time to perform light physicals. Milwaukee area. Professional liability provided. Phone 414/344-2100, Ms Jenkins. 10tfn/84

Wisconsin. BC/BE Pediatrician to join busy five-member pediatric department in 50-member multispecialty group, adjacent to only hospital in city. Salary one year leading to full partnership. City of 55,000 in pleasant southern Wisconsin. Send CV to: Patrick Meyer, MD, Janesville Riverview Clinic, Ltd, 580 North Washington Ave, Janesville, WI 53545; ph 608-755-3500. p8/88

Baraboo, Wisconsin. Emergency Department at St Clare Hospital seeks full and part-time physicians. Eight thousand annual visits. Hourly compensation. Pleasant area in which to live, near Devil's Lake and the Baraboo Hills. Also, Madison nearby. Contact: Mr Ronald Levy, President, St Clare Hospital, 707 14th St, Baraboo, WI 53913, ph 608/356-5561. 6–8/88

General Internist. Marshfield Clinic, a 260-physician multispecialty group practice, is seeking BE/BC General Internal Medicine specialists to join its expanding department in Marshfield, Wisconsin. The department is currently staffed by 23 general internists with immediate plans to add seven or more additional members. The current call schedule is generally one night per month and one out of five weekends. An Internal Medicine Residency Program, University of Wisconsin Medical School affiliation, Medical Research Foundation, and ongoing new developments, ie, Geriatrics Evaluation Center and Walk-In medicine contribute to a very stimulating environment. Our community of 20,000 offers strong economic stability combined with exceptional recreational, cultural, and educational opportunities. We offer a current starting salary up to $85,000 with salary in two years up to $110,000. Fringe benefit package outstanding. Send CV and references to: David L. Draves, Department of Administration, 1000 North Oak Ave, Marshfield, WI 54449 or call collect 715-387-5376. 8/88

General Surgeon and **Family Practice** opportunities in a group setting. Located in a family-oriented economically strong small city. Located near lakes and metro area of Green Bay and Appleton, Wis. Send CV to Andrew Lagatta, President, Clintonville Community Hospital, 35 N Anne St, Clintonville, WI 54929. 6–10/88

Rheumatologist—the Racine Medical Clinic, a 34-physician multispecialty group conveniently located between Chicago and Milwaukee. Well equipped clinic offering salary guarantee with incentive bonus; excellent fringe benefits and early ownership. Please send curriculum vitae to: R.D. Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 11tfn/87

BC/BE Family Practice to join six-BEFP and one BC general surgeon in scenic northern Wisconsin. Outstanding recreational area. New clinic facility attached to hospital. First year salary with production incentive. Please send CV/contact Paul Goellner, MD, Northwest Medical Center, 707 Ash Street, Spooner, WI 54801; ph (715) 635-2151. p6;7–8/88

Physicians Exchange

continued

Family practice. Thirty-four physician multispecialty group conveniently located between Chicago and Milwaukee. Well-equipped clinic offering salary guarantee with incentive bonus; excellent fringe benefits and early ownership. Please send current curriculum vitae to Roger D. Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 4tfn/88

General Surgeon with some general medical experience seeks position with small group, individual or hospital in Wisconsin or northern Michigan peninsula. Mature status but good health and wide training and experience in general surgical field and endoscopy. Currently available. Ph 218-338-4678 or contact Dept 619 in care of the Journal. 8/88

This space available
BOXED: $25.00
(1 column inches)

Miscellaneous

Wanted to purchase: Established pediatric practice in Milwaukee. Days: (414) 771-0500; evenings: (414) 781-1497. 7-9/88

For Sale. IBM computer AT 512K, IBM enhanced color display and enhanced graphics adapters, $5,500. Santiago Medical Manager with six months of remaining support, $2,500. IBM "Doctors Office Manager," $500. C.ITOH printer, C-310 dot matrix and business printer with letter quality capability. 300 cps draft proportioned mode 62 cps near letter quality. For more information, please call (715) 479-2397, Tuesdays and Thursdays, 8:00 am to 4:30 pm. 7-8/88

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For Sale. Colposcope, Stereo Cryomedic 3001, applied fiberoptic light, complete sets of Prafft dilators with trays, luxurious Drexel desk, credenza, executive chair with two front chairs. All in excellent condition. Contact Dr Halfon at 414-658-1208 or 414-694-4060. p8/88

Real Estate

For Rent. Doctor's Office, Hales Corners, Wisconsin, area 1050 sq ft. New building, first floor, ample parking. Reception, business office, three plumbed examining rooms, laboratory, private office and bath. For information call 414-764-6692 or 414-744-8007. 8tfn/88

Secluded NW Wisconsin retreat. Forty acres, 550′ frontage on uninhabited 30 acre lake. Beautiful six sided, two story, three bedroom, full basement, custom modern home. Complete privacy, wildlife, and large pines. For more information write or call Buck McMinn, Box 296, Chelan, WA 98816; ph 509-682-5204. n/c

URGENT CARE POSITION

(BC/BE Internal Medicine)

Full-time faculty position in the general internal medicine section of the Department of Medicine, UW Madison. We are seeking a Physician to staff the Urgent Care Clinic at the University of Wisconsin Hospital and Clinics. This is a full-time clinical practice position and involves resident supervision. **Send CV to:**

Donald R. Harkness, MD
Chairman, Department of Medicine
J5/219, Clinical Science Center
600 Highland Ave.
Madison, WI 53792
Telephone (608) 263-1792

University of Wisconsin Hospital & Clinics

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Wisconsin Society of Internal Medicine 13

Medical Meetings—Continuing Medical Education

SEPT 9–11, 1988: Wisconsin Society of Anesthesiologists, Convention Center/ Embassy Suites, Green Bay. g10tfn/87

SEPTEMBER 16–17, 1988: Wisconsin Surgical Society Fall Meeting, The Americana, Lake Geneva. Info: J David Lewis, MD, 414-338-1123. g8/88

SEPTEMBER 29–30, 1988: *Advanced Trauma Life Support (ATLS) Provider Course,* at Gundersen Clinic/Lutheran Hospital, La Crosse, Wis. Info: Thomas H. Cogbill, MD, 1836 South Ave, La Crosse, WI 54601. 7–8/88

OCTOBER 1, 1988: *Wisconsin Society of Radiation Oncologists,* Concourse Hotel, Madison. 4tfn/88

OCTOBER 3–7, 1988: 54th Annual Scientific Assembly of the American College of Chest Physicians, Anaheim Convention Center, Anaheim, Calif. Info: Division of Education, American College of Chest Physicians, 911 Busse Highway, Park Ridge, IL 60068; ph 312-698-2200. g5–8/88

OCTOBER 20–21, 1988: Wisconsin Chapter, American College of Emergency Physicians, The Abbey, Lake Geneva. 2tfn/88

NOVEMBER 4, 1988: *Wisconsin Orthopaedic Society,* Olympia Resort, Oconomowoc. 4tfn/88

NOVEMBER 5, 1988: Wisconsin Allergy Society, InnTowner Hotel, Madison. Info: Robert Bush, MD, 2500 Overlook Terr, Madison, WI 53705; ph (608) 256-1909. gtfn/88

AMA

DECEMBER 4–7, 1988: Interim House of Delegates, Dallas, TX.

JUNE 18–22, 1989: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 3–6, 1989: Interim House of Delegates, Honolulu, HI.

JUNE 24–28, 1990: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 2–5, 1990: Interim House of Delegates, Orlando, FL.■

State Medical Society of Wisconsin

Dates and locations of ANNUAL MEETINGS 1989–1993

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the Hyatt Regency as the headquarters hotel, unless otherwise indicated.

1989—April 13–15
1990—April 26–28: ***Green Bay***
Convention Center, Embassy Suites
1991—April 18–20
1992—April 23–25
1993—April 15–17: ***La Crosse***
Convention Center, Radisson

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, WI 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

CONTINUING MEDICAL EDUCATION

Sponsored by Marshfield Clinic Marshfield, Wisconsin

1988–1989

SEPTEMBER 9–10, 1988: *Advanced Cardiac Life Support Course*—Marshfield

SEPTEMBER 21–22, 1988: *Selected Topics in Cardiology for Pharmacists*—Sentry Theatre, Stevens Point

OCTOBER 7–9, 1988: *Live Cutaneous Laser Surgery Workshop*—Marshfield

JANUARY 25–27, 1989: *Cancer 89*—Telemark Lodge, Cable

FEBRUARY 4, 1989: *Science Teachers Conference*—Marshfield

FEBRUARY 9–10, 1989: *Winter Pediatric Conference*—Big Powderhorn Ski Resort, Bessmer, Mich

MARCH 10–11, 1989: *Advanced Cardiac Life Support Course*—Marshfield

For further information or a brochure call the Marshfield Clinic's Office of Medical Education, 1000 North Oak Ave, Marshfield, WI 54449; ph 715-387-5207. 8/88

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, clinics, specialty societies, and medical schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 50¢ per word, with a minimum charge of $20.00 per listing. *All listings must be prepaid.*

BOXED LISTINGS: $25.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 1st of the month preceding the month of publication; *eg,* copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free in Wisconsin: 1-800-362-9080.

FOR LISTING of other meetings see the July 1, 1988 issue of the *Journal of the American Medical Association:* Continuing Education Opportunities for Physicians for period August 1988 through December 1988.

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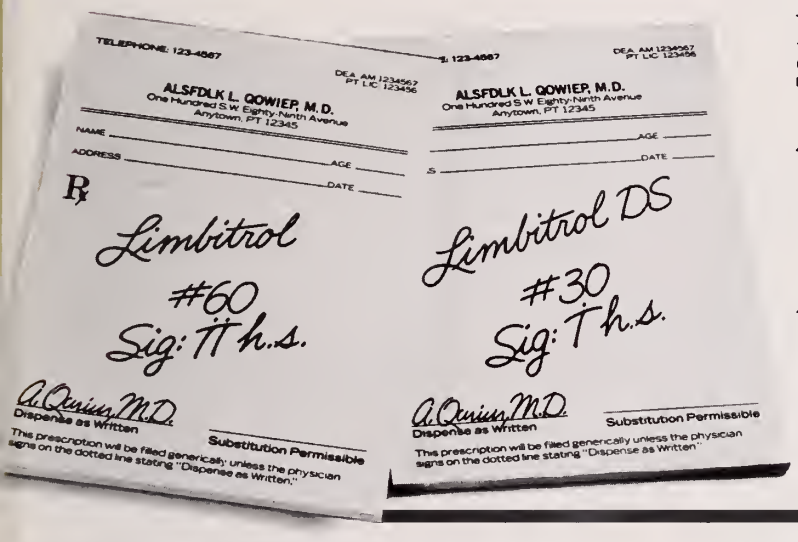

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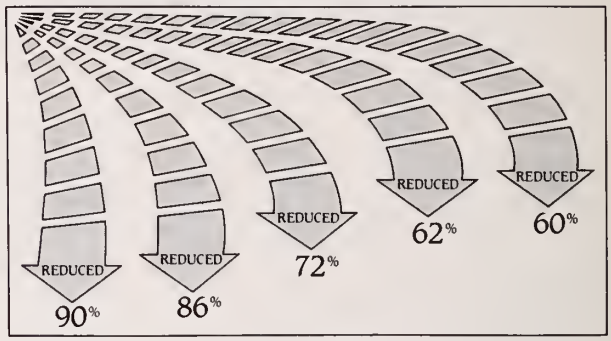

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V.87, NO. 9, Sept. 1988

Wisconsin Medical Journal

The *Wisconsin Medical Journal* (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor and editor are responsible for overseeing the production, business operation and contents of the journal. The editorial board, chaired by the medical editor, solicits and screens all scientific, special and soundings articles. The editorial director provides leadership for the editorial associates and comments on both editorials and letters to the editor. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *WMJ* nor the SMS take responsibility. The *WMJ* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

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Created by the Territorial Legislature in 1841 and now representing nearly 7,000 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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Our cover: This month's cover begins a new era for the *Wisconsin Medical Journal*—see Managing Editor Ron Henrichs' comments on page 9. The cover photo, "Door County Colors," is by *WMJ* editor Russell King.

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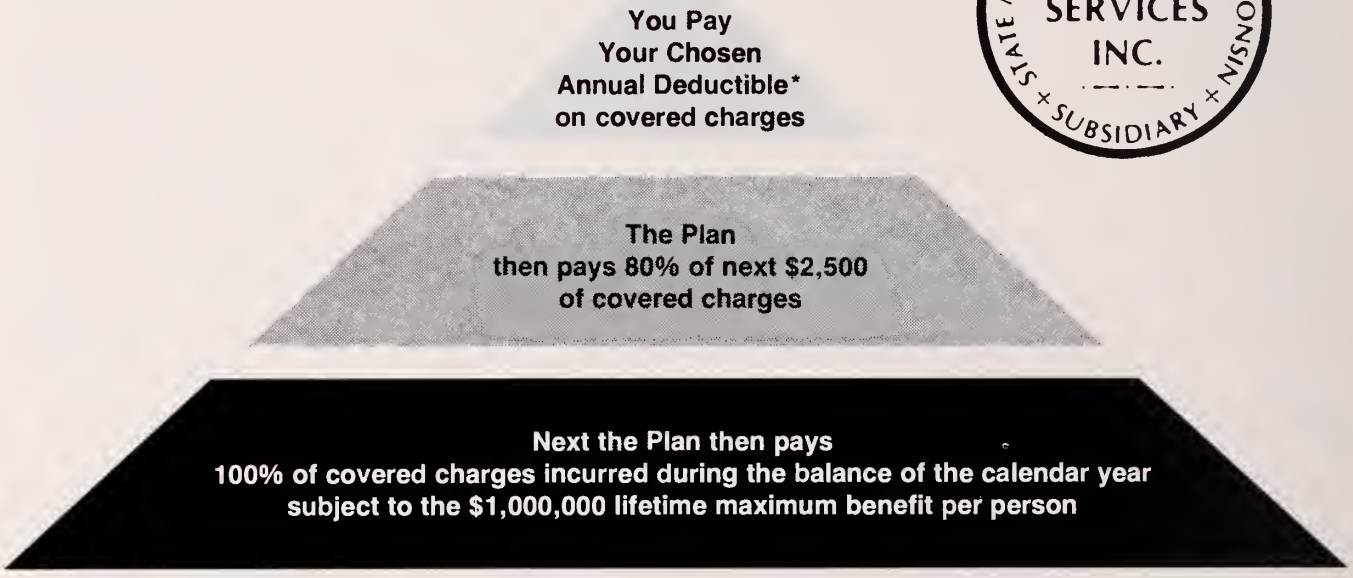

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President's page

A shortage of bedside nurses

A SHORTAGE of registered nurses at the hospital bedside has created concern, even alarm, among physicians in parts of the United States and Wisconsin. Some hospitals have had to delay admissions, postpone operations and even close beds for the lack of bedside care personnel. As things stand now, the bedside nurse shortage is projected to grow worse over the next dozen years. Organized nursing and organized medicine concur that there are, and that there will be, too few bedside nurses. Each tends to blame the other for the problem, and neither has yet been able to agree on a single, sovereign remedy.

A coalition of professional nurses' organizations, including the Wisconsin Nurses Association, the American Nurses Association and others, proposes increasing the availability of bedside registered nurses by: 1) expanding federal, state and private funding for loans and scholarships for nursing school applicants; 2) improving the use of nurses now employed through better use of more support personnel for administrative tasks and computerized charting; 3) higher pay and better incentives for experienced bedside nurses; and 4) improvements in the environment in which care is provided.

According to nursing educators and leaders, modern bedside nursing has become so technical and complex that professional (baccalaureate degree) registered nurses assisted by technical (associate degree) registered nurses are essential to proper patient care. For this reason, professional nurses' organizations have for years recommended against continuation of programs providing lesser training. Because of higher costs and fewer applications, most diploma (hospital) schools of nursing have closed. Concurrently, enrollment in college schools of nursing has plummeted.

For years the policy of the AMA, as determined by its House of Delegates, has been to support nursing education at all levels—practical, diploma, associate, baccalaureate and advanced degree—to meet the increasing needs of patients for both basic and complex bedside care in which two-thirds of nurses are now employed. Organized medicine has acknowledged that low pay for experienced nurses, irregular and inconvenient hours, and a stressful working environment create recruitment and retention problems, and the AMA has supported organized nursing's efforts to devise solutions.

Physicians and hospital administrators around the country have become alarmed by the growing shortage of bedside nurses, the fall in enrollment in collegiate nursing schools, the demise of hospital nursing schools, the decline in popularity among talented young people of nursing as a vocation, and a drift of registered nurses away from the bedside into other roles within and without their profession.

JD Kabler, MD

In this context, the AMA House of Delegates, during its June 1988 meeting, after prolonged debate—which included contributions from leaders of professional nursing organizations—authorized implementation of a *pilot* program to recruit and train a new category of bedside care personnel, the registered care technologist (RCT). The RCT is described as a bedside care giver who carries out physician orders at the direction of the head nurse in the hospital and long-term care facilities. The RCT's role is task-oriented, non-managerial and designed to serve patients as would a corpsman or corpswoman in a military hospital. The RCT is in-

Continued on page 4

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Continued from page 3

tended to supplement, not supplant, the nurse. The RCT proposal is controversial and there are associated unsolved problems which may defy resolution: cost, reimbursement, legislative and educational.

How will all this turn out? Do we need yet another health worker at the bedside? Will this proposal alienate nursing by encroaching upon nursing's educational and professional domain? Can the nursing and medical proposals be blended (they are not mutually exclusive) to provide a solution to the bedside nursing shortage? Will intelligent, talented and energetic young people who have heretofore been the mainstream of nursing continue to flow instead into medicine, engineering, business and the law? Will young adults avoid *all* health care occupations and instead choose careers less hazardous and less demanding?

Whatever the future answers to these questions, contemporary nursing and medicine have no sensible option but to strive together, locally and nationally, to devise rational responses. Our patients expect and deserve no less.■

A call for photographs

The *Wisconsin Medical Journal* and the SMS Charitable, Educational, and Scientific Foundation are joining forces in an effort to build a photographic library of medicine in Wisconsin. Donations of current or historical photos relating to medicine—persons or places, equipment or events—are welcome and tax deductible. All donated photos will become the property of the Fort Crawford Medical Museum, which is owned and operated by the foundation, and may be used to illustrate future issues of the *Wisconsin Medical Journal.* Send your photos to: Kristin Bjurstrom Krueger, State Medical Society of Wisconsin, PO Box 1109, Madison, WI 53701-1109.■

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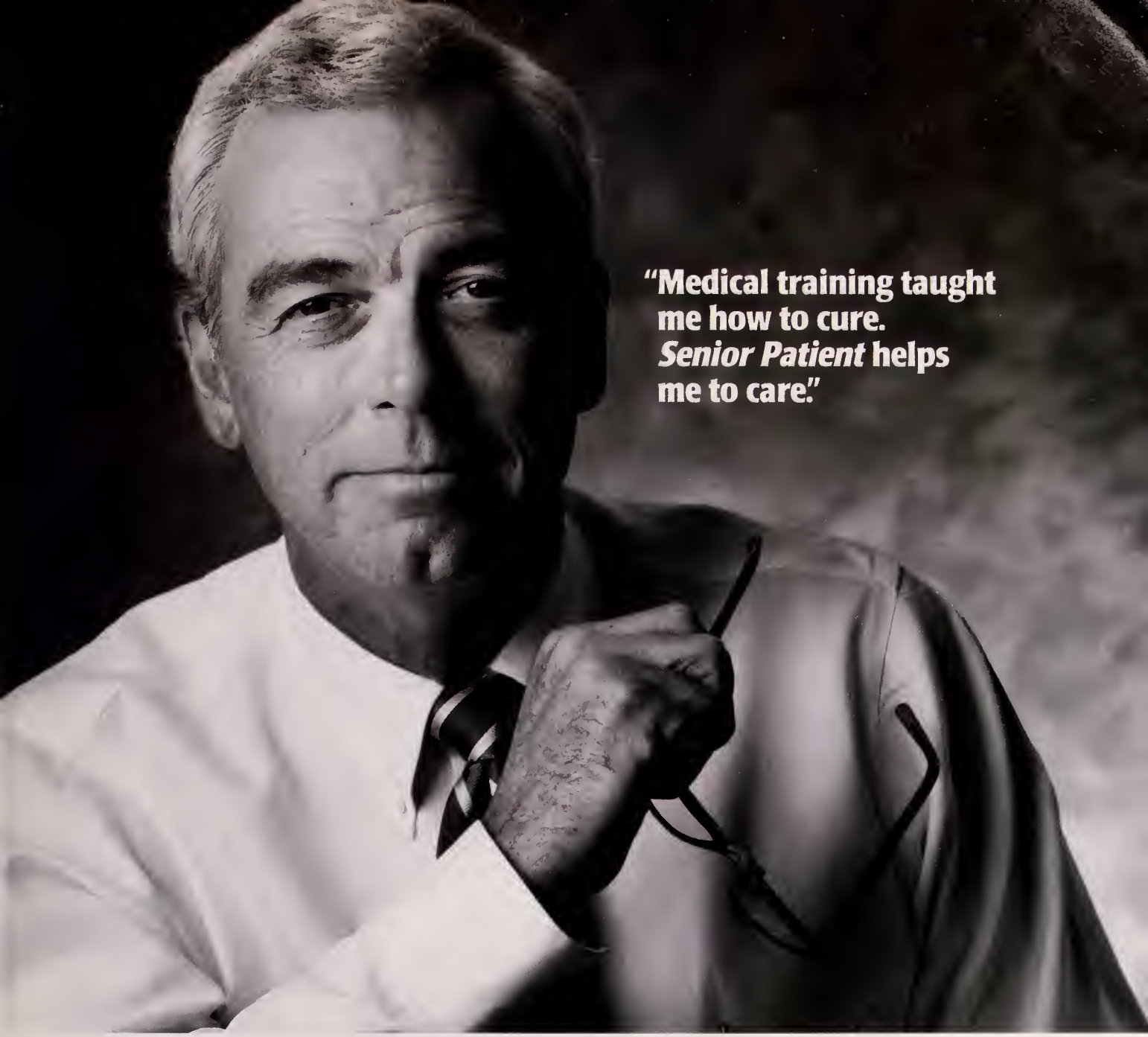

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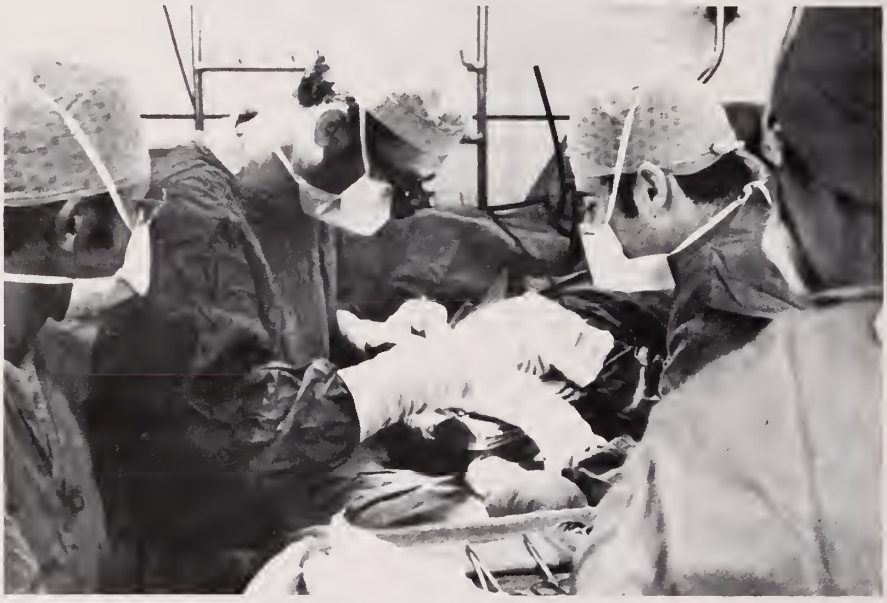

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Voice of the SMS

An opportunity missed

THE CURRENT FEDERAL ADMINISTRATION was handed a golden opportunity by its own AIDS commission last month to galvanize the nation into action against the AIDS epidemic. It could have voiced strong support for the commission's ambitious and well thought-out report and used its authority to implement its recommendations; instead, it ignored or diluted many of plan's key recommendations—including prohibiting discrimination against those infected with the AIDS virus—and concentrated on the need for more studies.

The presidential Commission on the Human Immunodeficiency Virus (HIV) Epidemic, chaired by retired Admiral James D. Watkins, in June fulfilled its charge to recommend a national policy for dealing with AIDS. Containing nearly 600 recommendations, resulting from 43 days of hearings and nearly a year of study, the report was generally agreed to by all 13 commission members.

"The single most significant obstacle to progress in controlling the epidemic" is discrimination against those infected with the AIDS virus, Admiral Watkins said in releasing a draft of the report. Discrimination affects virtually every element of the AIDS problem, not only the individual—in terms of employment, insurance, housing and treatment, he said, but also researchers' and health agencies' efforts to gather data for estimating the prevalence of AIDS. The report called on the president to ban discrimination immediately through executive order and on Congress to develop stringent anti-discrimination laws. "Discrimination against persons with HIV infection is unwarranted because it has no public health basis," the report said.

The recommendations of the State Medical Society's Task Force on AIDS, approved as official SMS policy by the House of Delegates last spring, also addressed the issue of discrimination. The Task Force said that an important principle underlying its recommendations was the prohibition against discrimination. "We strongly endorse prohibiting discrimination in housing, employment, and education for HIV-infected individuals when the public health authorities have confirmed that no risk exists for non-infected individuals," the Task Force said. "People who are HIV infected should not be treated unfairly or suffer from arbitrary or irrational discrimination in their daily lives."

Admiral Watkins, who confessed to knowing little about AIDS when he was appointed by the president, has done a commendable and courageous job. As US Surgeon General C. Everett Koop has learned, those who attempt to address the issue of AIDS rationally risk being attacked as promoting immorality and encouraging homosexuality.

Unfortunately, the administration, unlike Admiral Watkins, seems to have chosen to avoid controversy. In response to the commission's report, it quietly released a ten-point "action plan." The plan also considered the discrimination issue, but, while calling on Americans not to discriminate against persons with the AIDS virus, limited legal protection to federal employees. It also directed the attorney general to study whether additional federal action is necessary.

Meanwhile the AIDS storm continues to rage. The World Health Organization estimates that by 1991 there will be a five-fold increase in the total number of AIDS cases, and in the West, AIDS will become the primary cause of death among men 25 to 34, greater than the total deaths in that group from the four current major causes of death—traffic accidents, suicide, heart disease, and cancer. In the US, more than 1.5 million persons are infected with the virus, and 68,000 have been diagnosed as having AIDS. One thousand of these are children, many of whom acquired the disease before they were born.

As Admiral Watkins said: "We waste a lot of time on a couple of little issues, while the forest behind us burns."■

Opinion policy

Opinions expressed as the Voice of the SMS reflect the official policy of the State Medical Society of Wisconsin.

Editorials express the opinions of the signed authors and do not necessarily reflect SMS policies. Authorship of editorials is reserved for members of the *WMJ* editorial board, editorial associates and SMS elected officers.

Letters express the opinions of the signed authors and do not necessarily reflect SMS policies. Authorship of letters is open to the public, but letters are limited to 500 words and subject to review by the editorial board.■

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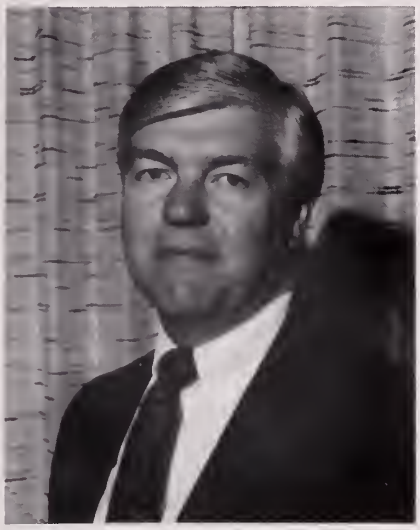
Welcome to the future

THE EVER-WHIRLING wheel of change;" wrote Spencer, "the which all mortal things doth sway," and it is on this wheel that the *Wisconsin Medical Journal* is moving forward once again.

This month's passing of the familiar red cover—a *WMJ* tradition since 1949—is only the most obvious of a number of changes phased in over the past few issues and planned for the future. It is also the most obvious symbol of the emergence of the next stage of the journal's 85-year evolution.

This new creature is designed for greater adaptability to the times. While maintaining its basic strength in scientific medicine, the *WMJ* is working toward comparable abilities in covering socioeconomics, practice management, legislative issues and organizational news. These are the demands of the modern medical climate, and the *WMJ*'s worth is measured by how well it helps physicians meet them.



Ron Henrichs, managing editor

Other, less noticeable, changes have given the *WMJ* a more modern design. We've brightened the pages and changed the type to make the *WMJ* easier to look at. We've paid more attention to editing while bringing our style into line with AMA standards to make the *WMJ* easier to read. We've introduced the new editorial, Voice of the SMS, to offer greater leadership and inspiration while fine-tuning our Editorials and Letters sections to support a greater forum for your opinions. And we've tightened the journal's organization while broadening its scope to provide you with more information without losing you in the clutter.

These latest changes, however, are only the beginning of a growth process that we hope will make the *WMJ* ever more useful and attractive to you. Mindful of the lessons of its history, and of the strength of its reputation, the *Wisconsin Medical Journal* looks now to a future of enhanced service to the SMS.■

Editorials

Our most precious resource

SHADES OF EXODUS. After languishing for years in obscurity, wandering aimlessly through the desert of pleading constituents and congressional indifference, child care legislation is finally reaching the Promised Land of committee debate and (music swells as the Red Sea parts) will come to a vote this fall.

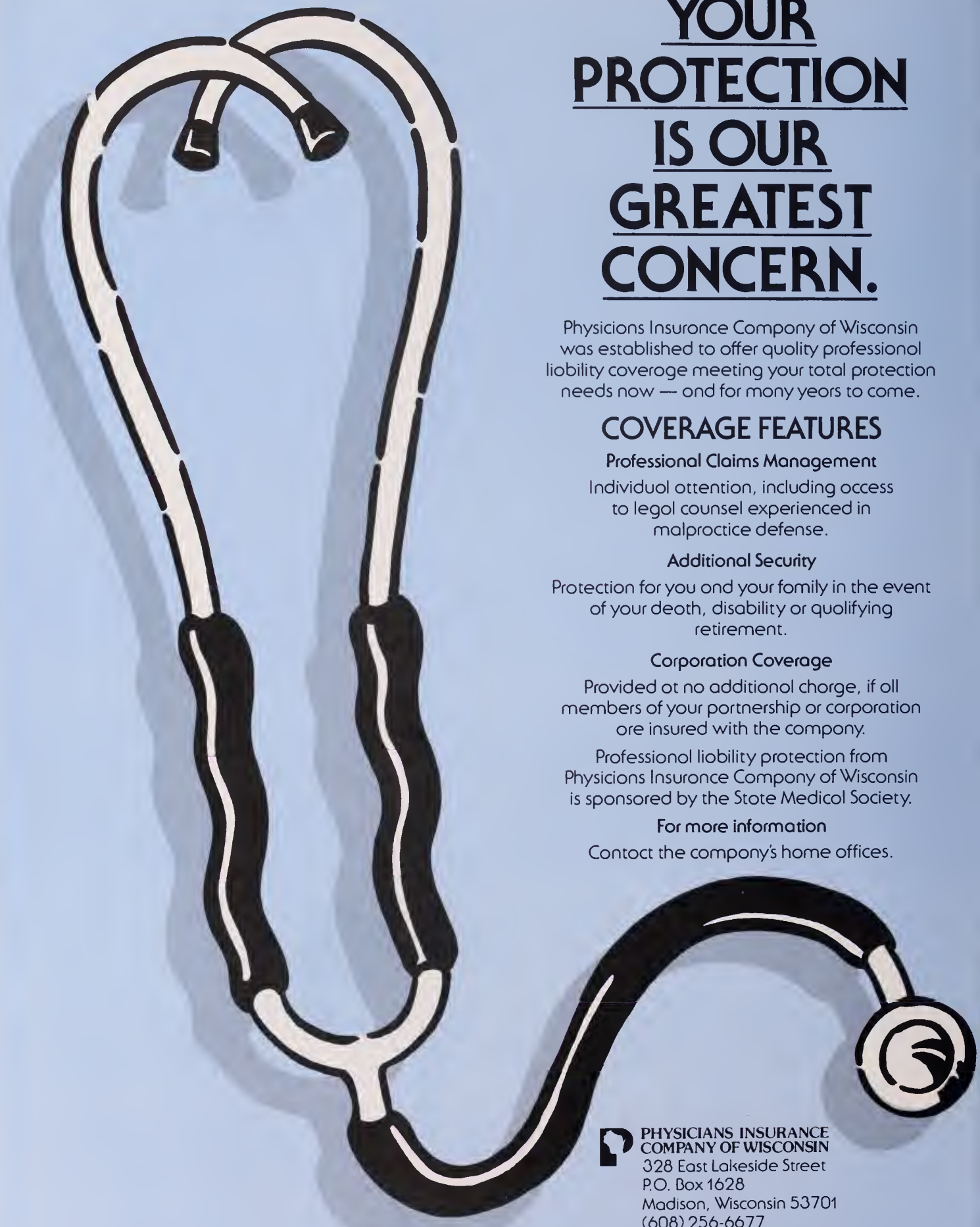
In typical election-year fashion, Congress has seized upon child care as one of the hot issues of the people during this campaign. A number of legislators have introduced bills addressing the issue of child care provision and regulation, among them Christopher Dodd, Orin Hatch and Robert Dole. The two front-running bills are the Act for Better Child Care—the so-called "ABC Bill," HR 3660, Kildee (D–Mich.); S 1885, Dodd (D–Conn.)—and the Child Care Services Improvement Act: HR 4002, Johnson (R–Conn.); S 2084–2085, Hatch (R–Utah).

There are several important differences between the bills. The ABC Bill earmarks $2.5 billion in the first year, 75% (or $1.875 billion) of which would be used to help low- and moderate-income families pay for child care. It is estimated that this money (plus 20% matching funds from state governments) would pay for day care for approximately 700,000 children per year—and the number increases if children in part-time day care are included. Fifteen percent of the money ($375 million) would be allocated to the states to help strengthen their systems of care. The ABC Bill further provides for the establishment of federal child care standards, with which the states would be expected to comply within five years.

In contrast, the Hatch bill allocates only $250 million for child care block grants for all 50 states. This money would be used not only to help pay directly for child care, but also for training programs, day care start-up costs, and administrative expenses. This is inadequate.

California alone spent $250 million in 1987 just to provide day care payment assistance. Furthermore, there would be no way to determine how much of the money a given state might use to actually help needy

Continued on page 11



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Continued from page 9

families pay for day care, since specific usage guidelines are not provided with the grants. Moreover, the Hatch bill makes no provision for national day care quality standards. The individual states would merely be expected to adhere to their own guidelines. This is unacceptable, given the current wide variance in the quality of state-provided children's services. As a rule, state resistance to federal legislation comes as a result of the wanting to do less than national legislation mandates.

Parents in need of day care for their children deserve more from society than a heartfelt *"caveat emptor."* Children are not society's burden: they are its future and its most precious resource. They deserve the superior protection of the ABC Bill—and when you think about it, so do we. Write or call your legislators today.

—Jeffrey H. Lamont, MD
Wausau■

Breaking

"WHERE'S THE CHARGE NURSE?"

"Breaking."

"Where's the ward clerk?"

"Breaking."

"I don't get any response from the x-ray department."

"They're breaking." (Such departmental togetherness is great, but it is a bit frustrating when you're trying to schedule an x-ray.)

What is this "breaking?" It does not refer to physical or mental breakdown, but rather to that national curse and menace, the coffee break. I developed an antipathy to the coffee break at an early age when I was a senior medical officer on a small island (big frog in a small pond). Coffee consumption is a hallowed Navy tradition and the Navy even has its own coffee roasting plant. Anyway, on this atoll called Flyspeck because of its appearance on the map in the western Pacific, every Quonset hut and tent in the medical compound had it's own "coffee mess." These were generally untidy affairs with spilled coffee and condensed milk disturbing my otherwise orderly island hospital.

I finally procured a magnificent four-foot high glistening coffee urn. Since we had no running water, a G.I. can was rigged overhead to supply the urn with distilled water. Furthermore, I assigned a young hospital corpsman to preside full-time over this beauty. Unfortunately, this did not immediately eliminate all of the individual

Continued on page 13

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Continued from page 11

coffee messes and some acrimony arose in the process. Finally, I developed a Pavlovian reflex resulting in profanity and an apoplectic appearance at the mere mention of the word "coffeepot." My coffee nerves never came from caffeine, but from the coffee break.

My antipathy has not abated over the years, and it probably has accelerated with aging. I am reluctant to admit it, but tradition has it that the coffee break originated in my old hometown of Stoughton, where there was a predominantly Norwegian population. The street where the coffee break began was appropriately nicknamed Coffee Street, and the brew of the coffee was potent as the pot never left the stove.

Although it has been a boon to the coffee industry, the coffee break is a real pain in the neck when one hopes to accomplish something in the hospital or office during the "breaking" periods.

—*Victor S. Falk, MD*
Edgerton■

Soundings

The secret in a casual parenthesis

Maureen A. Murphy-Greenwood, MD
Lyndon Station

I AM COMING TO YOU only because my wife has encouraged me to give it one more try. If you don't find anything, I give up." These were the words that greeted me in my rural clinic, stated by a 52-year-old man, a patient new to me. A part of me wondered what it was that he thought I might be able to do for him, but I was primarily intent on listening to this desperate man.

"All of my life, for as long as I can remember," he said, "I have been tired. There has not been a morning when I have awakened and felt rested. Most anytime, especially at work, I can fall asleep at the drop of a hat. I look at people who are full of vigor and energy, and I get angry, wondering why I can't be like them." By then I was most intrigued by this man, and I listened on. "I have gone to so many doctors, have had all kinds of tests done at major medical centers, and no one can find anything wrong. I think they believe it is all in my head. I don't want to go on like this anymore. That's why I have come to you. Can you help me?"

I considered protesting, "But I am only a family physician in this small rural clinic. If physicians at major medical centers could not find out what is wrong with you, how can you expect me to help you?" He had come to me, however, with a legitimate request, and the least I could do was explore the problem. So I asked some questions and listened.

"Do I snore? My wife says I used to wake up the children by my noise at night. In fact, she says the only time I am quiet is when I suddenly stop breathing. She often worries that I may not start breathing again." Other than the tiredness and sleep abnormalities, the patient's review of his symptoms was negative. There was little doubt in my mind about what was going on; the patient had obstructive sleep apnea. Surprisingly, on physical exam there was a palpable scalene node on the left. When the patient was asked about this, he stated that the node had been enlarged for at least ten years. He agreed to have a CBC and a roentgenogram, both of which were normal.

On his next visit, several weeks later, a physical exam showed generalized lymphadenopathy. A biopsy of a left axillary node was performed and poorly differentiated lymphocytic lymphoma was found. A lymphangiogram and liver-spleen scan were done, and the patient was found to have stage 4 disease.

Chemotherapy treatment with adriamycin, cytoxan, vincristine, and prednisone was begun, and his lymphadenopathy diminished markedly. After the initiation of chemotherapy, a sleep study to evaluate his possible sleep apnea was undertaken; results were normal. In addition, the patient reported that since the institution of chemotherapy, his sleep disturbances had disappeared, and that he felt more rested than he had in years.

We presume that this patient had suffered from obstructive sleep apnea caused by the enlargement of retropharyngeal nodes involved with his lymphoma. Diminution of lymph nodes size after starting therapy resulted in resolution of his sleep symptoms.

Medically, this case points out some interesting phenomena: posterior pharyngeal lymphoma causing obstructive sleep apnea (there is vir-

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Dr Murphy-Greenwood is with the Lyndon Station Clinic. Reprint requests to: Maureen A. Murphy-Greenwood, MD, Lyndon Station Clinic, Lyndon Station, WI 53944 (phone: 608-666-2425). Copyright 1988 by the State Medical Society of Wisconsin.

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Continued from page 13

tually nothing published about this); the advantages of withholding initial therapy in advanced indolent lymphoma;[1] and the incidence of development of aggressive histologic subtypes in patients with indolent lymphomas.[2]

The most impressive aspect of this patient's case, however, is not the medical rarity of his condition, but that it brought to life a basic (but often forgotten) principle in medicine: listen to your patient. Busy schedules and pressing time constraints, however, may lead many physicians to listen only to patients' words and not hear their messages. The patient in this case felt frustrated because he felt he had not been listened to, and perhaps, even more important, had not been believed.

The challenge, then, is to listen to each patient closely and attentively, as if you are hearing his or her story for the first time. We cannot assume that all that can be done has been done just because a patient has gone to a major medical center. Technology and specialization have their role, but in many cases, listening is the most important thing that can be done. This is well expressed by William Trotter, the great English neurosurgeon (1872–1939):

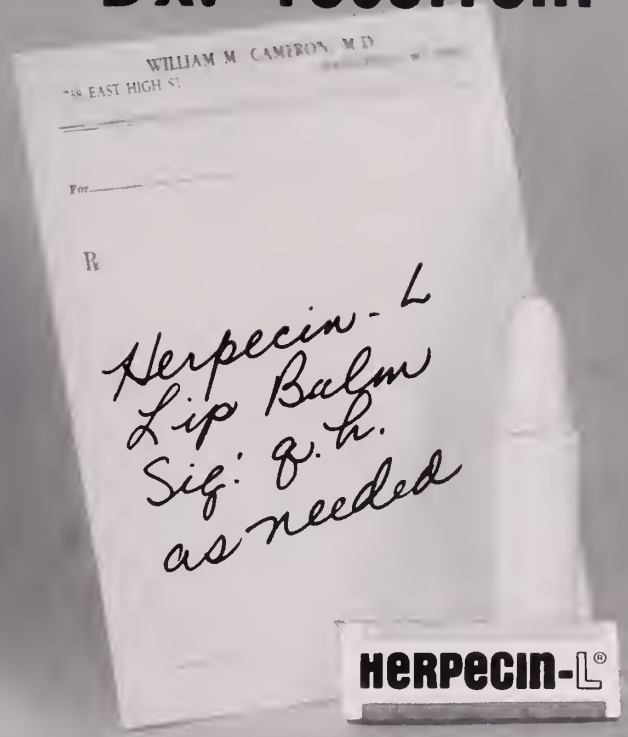
> As long as medicine is an art, its chief and characteristic instrument must be human faculty. We come therefore to the very practical question of what aspects of human faculty it is necessary for the good doctor to cultivate . . . The first to be named must always be the power of attention, of giving one's whole mind to the patient without the interposition of oneself. It is an active process and not either mere resigned listening or even politely waiting until you can interrupt. Disease often tells its secret in a casual parenthesis.

Fortunately for this patient, listening one more time revealed his "secret," and healing was brought about.

References

1. Petlock, C: Deferral of initial therapy for advanced indolent lymphomas. *Cancer Treat Rep* 1982;66:417–9.
2. Cullen MH, Lister TA, Brearley RL, et al: Histological transformation of non-Hodgkin's lymphoma: A prospective study. *Cancer* 1979;44:645–51.■

Dx: recurrent herpes labialis



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Blue Book update

Please refer to page 114 of the 1988 Blue Book edition of the *WMJ;* the following changes have been made to the list of Wisconsin specialty societies presidents and secretaries.

Wisconsin Academy of Family Physicians
P—*Curtis W. Bush, MD*
130 Warren St
Beaver Dam, 53591
PE—*Richard G. Roberts, MD*
777 S Mills St
Madison, 53715

Wisconsin Society of Otolaryngology—Head and Neck Surgery
P—*S. Thomas Donovan, MD*
1313 Fish Hatchery Road
Madison, 53715
PE—*Donald S. Blatnik, MD*
2400 South 90th St
West Allis, 53227
ST—*Terrence W. Frank, MD*
600 Highland Ave
Madison, 53792

Wisconsin Urological Society
P—*Richard Bourne, MD*
2600 Mayfair Road
Milwaukee, 53226

Wisconsin Society of Radiation Oncologists
P—*Homer H. Russ, MD*
611 St Joseph Ave
Marshfield, 54449
VP—*Sally N. Schlise, MD*
St Vincent Hospital
835 South Van Buren
Green Bay, 54305
S—*Richard A. Steeves, MD*
K4/B100 UW CSC
600 Highland Ave
Madison, 53792
T—*J. Frank Wilson, MD*
8700 W Wisconsin Ave
Milwaukee, 53226

Please refer to page 66 of the 1988 Blue Book edition of the *WMJ;* the following changes have been made to the Medical Examining Board member list.

G. Thomas Pfaehler, MD (1989), Madison, chairman
Arlen Delp, DO (1990), Muskego, vice chairman
Henry M. Waldren, Jr, MD (1990), West Allis, secretary
Patricia O'Flynn Thomas (1992), Milwaukee, public member
B. Ann Neviaser (1992), Madison, public member■

Benefits from adjuvant therapies for colorectal cancer small

Adjuvant therapies such as chemotherapy and radiotherapy do not appear to provide any additional benefit over surgery alone in treating colorectal cancer, a study published in a recent issue of *JAMA* reports. Based on a review of all randomized control trials of adjuvant therapy for colorectal cancer published in English up to December 1986, the authors found no statistically significant benefit from any other chemotherapy or radiotherapy. One exception may be the use of fluorouracil for at least one year, which appeared to increase the five-year survival rate among treated patients by 3.4%.

The authors examined 17 trials (totaling 6,791 patients) that compared groups receiving adjuvant chemotherapy for colorectal cancer with control groups treated only with surgical removal of tumors and eight trials (totaling 3,062 patients) that compared radiotherapy groups with control groups for rectal cancer.■

Dr. Tipton and residents examining post-operative patient in recovery room.

DALE L. TIPTON, M.D.

Associate Clinical Professor, Department of Otolaryngology, Head and Neck Surgery, University of California School of Medicine, San Francisco, California.
Chairman, Division of Otolaryngology, Franklin Hospital, San Francisco, California.
Lieutenant Colonel, U.S. Army Reserve.

EDUCATION University of California at Berkeley, A.B. Physiology; University of California School of Medicine, San Francisco, M.D. and Master of Science, Pharmacology.

RESIDENCY University of California School of Medicine, San Francisco: General Surgery – 2 years; Otolaryngology – 3 years.

FELLOWSHIPS National Institute of Health Fellow; Cancer Research Institute, University of California, San Francisco.

OUTSTANDING ACHIEVEMENTS Freshman Medical Student Research Award; Class President – 2nd year medical school; Student Body President – senior year medical school; Special Award by National Institute of Health to attend and present paper at International Congress of Otolaryngology in Tokyo, Japan; Chairman, Department of Otolaryngology, San Francisco General Hospital 1970-76; Chief of Medical Staff, Franklin Hospital 1982-84.

"I joined the Army Reserve shortly after completing my responsibilities as Chief of Staff of Franklin Hospital in San Francisco. I was intrigued with the idea of trying something different, such as Army Medicine.

"I find that the challenges and rewards of serving as an Army Reserve physician complement my civilian practice. For a number of years, I've been teaching as a member of the Clinical Faculty at the University of California School of Medicine, and I thoroughly enjoy the many teaching opportunities available to me in the Reserve. It is a rewarding experience to be involved in the training of Army medical students, interns, and residents. I also enjoy interacting and exchanging information with full-time Army physicians and seeing a wide variety of interesting clinical cases.

"After 18 years of private practice, I find it stimulating to be able to use my experience and expertise in a totally different medical setting. I highly recommend Army Medicine to any interested physician."

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Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients, at a reduced dosage of 150 mg h.s. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

Drug Interactions—No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported, it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Overdosage: There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LO_{50} values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

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A survey of vitamin use

James E. Casanova, MD, and Pamela Riendl, RN, MS, Milwaukee

Abstract: To determine the extent of vitamin use and sources of information and supply, patients in a private general internal medicine practice were given the opportunity over two months to complete a questionnaire while waiting for their appointments; 176 chose to participate. Results revealed that 1) 76% used vitamins; of these, two thirds were daily users, and one third reported occasional use; 2) 80% of vitamin users reported eating a well-balanced diet; 3) friends were mentioned most frequently as sources of vitamin information, with physicians being second; and 4) vitamins were purchased most frequently in pharmacies. From our study and others, it appears that most private office patients take vitamins. Physicians could reduce expenditures for unnecessary vitamins and prevent potential ill effects from these products by discussing vitamins during regular office visits. Further study is needed to evaluate the quantity and quality of advice being given by physicians.

AMERICANS SPEND NEARLY $3 billion annually on vitamins and nutritional supplements,[1] an impressive amount considering that recent annual federal government health expenditures included $72 billion for Medicare and $1.1 billion for maternal and child health programs.[2] Medical investigators report that most Americans do not need vitamin supplements and some may, in fact, be harming themselves with inappropriate use.[3-5] In medical practice, it is not unusual to find patients who describe complicated rituals of taking vitamins and supplements.

Only 13 substances are true vitamins, ie, substances required in small amounts for human metabolism, but not synthesized by the human genome. The lay public often uses the term "vitamin" erroneously to include a variety of substances and minerals purported to ensure good health and treat conditions as varied as jet lag, arthritis, mountain sickness, cancer, and recovery after vasectomy. Special regimens are also recommended for runners, gamblers, and even TV viewers.[6] Recently, vitamins have been marketed particularly to cope with stress.[7]

Little information is available regarding the impact of physicians and health care professionals on consumer vitamin use. A recent survey, during which investigators posed as consumers, reported that 17 of 30 pharmacists questioned recommended the use of vitamins for complaints of "nervousness" or "feeling tired."[7] Several studies have attempted to quantitate and describe vitamin use in various populations,[8-12] but none of these was conducted in a private internal medicine practice.

Methods

A preliminary survey was recently conducted of patients in a private internal medicine practice to determine the extent of their vitamin use and to identify their sources of information and supply. Over a period of two months, patients were provided the opportunity to complete questionnaires while waiting for their scheduled appointments. Questionnaires were made available in the waiting room, but no active recruitment was performed by the office staff. Of approximately 1,000 patients seen over the two-month period, 176 completed the questionnaire.

The majority of respondents were women who were married and who considered themselves to be in excellent or fair health. Nearly all were high school graduates, and one fourth had college degrees. The mean age was 55 years, with a range of 17 to 92.

Results

Seventy-six percent of the respondents reported using vitamins. Of

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these, two thirds were daily users, and one third reported occasional use. Vitamin users were likely to be married and to report eating a well-balanced diet (80%). The most frequently used product was a multiple vitamin (49%), while 24% reported taking vitamin C, vitamin E, or both, and 13% said they took B vitamins. Other reported products were vitamin D, vitamin A, calcium, zinc, potassium, lysine, selenium, alfalfa, oil of evening primrose, magnesium, cod liver oil, garlic and parsley. Seven percent of the women under 40 reported taking iron, and approximately one third of the women over 40 used calcium supplements.

Vitamin users mentioned friends most often as their source of vitamin information (37%), followed by physicians (35%), magazine articles (27%), and pharmacists (21%), with advertisements, nutrition stores, and TV or radio programs following in decreasing order. More than two thirds of all respondents were aware of potential dangers associated with vitamin use, and 8% specifically mentioned vitamin A or fat soluble vitamins as sources of danger. Only one patient mentioned receiving information from a physician about potential dangers of vitamins.

Patients took vitamins most frequently to prevent disease (30%) and to increase energy (26%). Other reasons mentioned included nutritional supplementation (for perceived dietary inadequacy), treatment of colds, stress, prostrate disease, and the prevention of wrinkles and aging. The majority of patients bought their vitamins at pharmacies (52%), and 12% or fewer relied on supermarkets, nutrition stores, door-to-door sales, or mail order services.

Discussion

This survey further documents the widespread use of vitamins and nutritional products, a very common and private form of self-treatment affected by a multiplicity of product claims and other poorly defined influences. Our finding that the majority of patients who took vitamins also reported eating a well-balanced diet suggests that taking these products may often be unnecessary. On the other hand, the amount of iron and calcium taken by women in this study may be insufficient. Vitamin use may also give patients a false sense of security and lead to the neglect of other important personal health habits.

The question of how patients initially develop their habits and rituals does not have a simple answer. More than a third of the users said they received advice concerning these products from a physician, but they also identified many other sources of information and influence. In fact, peers may wield more influence than physicians. The accuracy of the information received from all sources, including peers and health professionals, remains undetermined. The data are reassuring, however, as they suggest that most patients obtain these products from reputable sources, eg, pharmacies, and that many are aware of the possibility of toxicity from improper use.

A larger percentage of our sample population used vitamins than has been previously reported. This may be due to the particular type of practice studied or that use of these products is actually becoming more widespread. Another possibility is that the low response rate and lack of true random sampling introduced self-selection bias.

The results of this survey, however, have definite implications for primary care physicians. Since many patients are already taking vitamins and supplements, physicians should address this subject during regular office visits. Consumer awareness of unnecessary supplementation may result in decreased spending on vitamins. The money thus saved could be directed toward other health maintenance activities, eg, purchasing walking shoes, exercise equipment, a healthier diet, or iron and calcium supplements if necessary. Potential ill effects of inappropriate vitamin use or interactions between supplements and other drugs could also be prevented.

Recommended dietary allowances (RDA) of essential nutrients are well established.[4] There is no evidence that healthy people eating a well-balanced diet need supplements.[13] A balanced diet is generally defined as one that includes a variety of foods from each of the four basic food groups (meat, fruits and vegetables, milk, and grain groups). It should daily include four servings from the fruit and vegetable group, four servings from the grain group (cereals, breads, crackers, etc), two servings from the milk group (milk, yogurt, cheese, etc), and two servings from the meat group (meat, fish, poultry, nuts, beans, eggs, etc).[14] Most nutritionists agree that dietary deficiencies of essential nutrients in healthy people are best treated by simply improving the diet. Instances where additional supplements are indicated include pregnancy and lactation, infancy, strict vegetarianism, and prolonged weight reduction programs with caloric intakes of less than 1,200 calories. In addition, iron supplementation may be indicated in menstruating women, and calcium supplementation may be useful after menopause.

Conclusion

Does vitamin E prevent cancer? Do B vitamins "release energy"? Does selenium retard atherosclerosis? Questions like these continue to arise as our understanding of vitamins evolves. It seems that new claims for vitamins make the headlines almost daily, but, unfortunately, anecdotes and bizarre claims are reported on as frequently as substantive reports. Primary care physicians need both motivation and expertise to guide patients through a modern landscape that is littered with facts and fads.

Data such as ours may provide motivation, but further study is needed to evaluate the quantity and quality of professional advice now being provided. Training programs,

the medical literature, and continuing medical education plans need to explore ways of keeping primary care physicians informed of the latest developments. If physicians are unable to provide sound advice, nonprofessionals—many of whom may be motivated by pecuniary interests only—will gladly step in to fill the void.

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Fetal-maternal hemorrhage

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Abstract: Fetal-maternal hemorrhage is a common entity. Only rarely, however, does it result in fetal hydrops. The case we present here is instructive in that the newborn showed profound asphyxia, fetal hydrops, and chronic iron deficiency secondary to prolonged fetal-maternal hemorrhage. With rapid assessment of the mother and the neonate, who required an uncrossmatched transfusion immediately after delivery, there was a satisfactory outcome.

FETAL-MATERNAL HEMORRHAGE generally has one of two outcomes. If the bleeding occurs repeatedly and in small amounts, fetal anemia evolves slowly and the fetus adjusts hemodynamically. An acute, large hemorrhage, however, may result in stillbirth or hypovolemic shock in the neonate. In our case, the neonate was born with fetal hydrops and associated iron deficiency.

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Case Report

A 27-year-old primipara went to her family physician for a routine checkup at 35 weeks gestation, at which time fundal height was found to be 32 cm. The prenatal course had been entirely normal. She was instructed to count up to 10 fetal movements per day. At 36 weeks, fundal height was still 32 cm, and the mother had noted less than 10 movements per day for the preceding three days, with no fetal movements noticed during the preceding 24 hours. A nonstress test[1] was inconclusive. Variable decelerations of fetal heart tones were noted by Pitocin stress test as well as late decelerations and loss of beat-to-beat variability.[2] Following emergency transfer, the woman delivered a 2.2 kg male by Cesarean section. The newborn was very pale and markedly edematous, and he had no audible heart beat, although occasional gasps were noted. He was actively resuscitated and had Apgar scores of 1 and 3 at one and five minutes respectively. The placenta was examined and did not appear to have any obvious pathology. Microscopic assessment was not carried out. Umbilical venous and arterial catheters were placed.

The newborn's initial white blood count was 35,300 μL, hemoglobin was 3.4 g/dL, and hematocrit was 10.6%. His blood group was O and Rh positive. Antibody screening and

Coombs' tests were negative. Reticulocyte count was 12.7%. Total serum protein was 2.6 g/dL, and albumin was 1.2 g/dL. Serum iron was 19 μg/dL; total iron binding capacity was 156 μg/dL; saturation of iron binding capacity was 12%; and ferritin was 281 ng/mL. No abnormal hemoglobins were identified on Hb electrophoresis, and Hb F was 85%. Initial arterial blood gas studies revealed a pH of 7.20, PCO_2 of 30 mm Hg, PO_2 of 78 mm Hg, and base excess of −15.5 mEq/L.

After the neonate was placed on a respirator and the umbilical catheters were inserted, an immediate partial isovolumetric blood exchange was performed with O-negative, uncrossmatched packed red blood cells. The preceding laboratory studies were performed on the initial blood withdrawn from the arterial line and a total of 60 cc of packed cells was exchanged. Hb level following the partial exchange was 10.6 g/dL.

Following the exchange transfusion, the cardiopulmonary status stabilized, and the neonate was weaned from the ventilator and extubated on the third day. Thoracic and abdominal ultrasound did reveal small pleural effusions and ascites respectively. The Kleihauer-Betke slide test on maternal blood was positive for 5.9% fetal blood cells representing a fetal-maternal hemorrhage of approximately 150 to 200 mL.[3]

The remainder of the neonate's hospital stay was unremarkable, and he was discharged at 13 days of age on an iron supplement. Examination at four months showed normal neural development.

Discussion

Fetal hemorrhage into the maternal vascular space is common[4,5] and has been estimated to occur in 50% of pregnancies.[6,7] The large majority of these episodes are of no clinical significance. By estimating the maternal red cell volume and knowing the percentage of fetal cells, one can predict the volume of the fetal-maternal hemorrhage.[8] In our case, the estimated fetal blood loss into the maternal circulation was 150 to 200 mL, which was equivalent to the total blood volume of the newborn. A hemorrhage of this degree obviously occurred over a protracted period.

This neonate was clearly deficient in iron. His serum iron was 19 μg/dL and total iron binding capacity was 156 μg/dL. The normal cord blood mean serum iron is 154 μg/dL with a range of 72 to 237 μg/dL.[9] The normal cord blood total iron binding capacity has a mean of 240 μg/dL with a range of 147 to 468 μg/dL.[10] One could predict that this neonate would have had an increased iron binding capacity if he hadn't had hydrops with secondary hypoproteinemia and impaired protein synthesis. He did, however, have a low normal iron binding capacity with decreased iron saturation secondary to chronic iron depletion. Normally, saturation of transferrin remains relatively constant at 60%.[11]

Serum ferritin values are generally much higher in the newborn than in older children and adults.[12] Serum ferritin levels at birth have a mean value of 100 ng/mL and then increase rapidly to an average of 356 μg/mL by 1 month of age. Throughout the first six weeks of life, there is a wide range of values with responsiveness to many different stimuli as noted in this case.

The fundal height and the woman's report of decreased fetal activity led to concern for the fetus's well-being. Fetal heart monitoring was crucial in this case, and the neonate's life was saved because the physician appropriately responded to the variable and late decelerations in heart tones. The case is unique and instructive because of the neonate's degree of anemia with associated iron depletion, asphyxia, hydrops, and his response to an emergency partial isovolemic exchange transfusion with packed red blood cells. In this case, the use of uncrossmatched blood was lifesaving.

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Clinical cancer: 26

Interventional radiology in cancer

Andrew B. Crummy, MD, and
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INTERVENTIONAL RADIOLOGY may be defined as the application of modified diagnostic radiology techniques for therapy. Such maneuvers have been carried out for many years, eg, the hydrostatic reduction of the ileocolonic intussusception with a barium enema. Recently, there has been a great increase in the types of intervention, and the opportunity to benefit cancer patients has expanded.

The body is a superb plumbing apparatus. There are a number of pipes, such as the vascular and lymphatic systems, the gastrointestinal, biliary, respiratory, urinary tracts, and cerebral ventricles, and subarachnoid space. Many of the problems in the body related to neoplasms are due to disruption of flow in the various pipes, such as obstructive uropathy, jaundice, or leaks—eg, bleeding—which result in extravasation with a seemingly endless variety of undesirable consequences.

Interventional radiology in many circumstances provides an alternative method of treatment for these obstructions and leaks, as well as a simplified method of performing biopsy. In general, it is less taxing on the patient and less expensive than surgery, the traditional approach. Therefore, it is essential that the physician caring for the patient with cancer be aware of the advantages and the limitations of the interventional radiological and surgical methods. He or she will then be able to recommend to the patient the method that will best accomplish the objectives.

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In 1953, Sven Seldinger of Sweden described the technique for percutaneous vascular catheterization. This method provides easy access to the vascular system and obviates the need for a surgical incision and an arteriotomy, both of which require suture closure at the end of the procedure. In the Seldinger technique, a nick is made in the skin and a needle introduced into the artery or vein. A guide wire is passed through the needle, which is then removed. A catheter, the end hole of which has a snug fit on the guide wire, is passed over the guide wire into the artery or vein. The guide wire is removed and fluid may be injected or aspirated. The catheter can then be advanced through the vascular system and, using various shapes, entry into branch vessels can be carried out with ease.

The basic requirement for Seldinger catheterization is a space in which the catheter and guide wire can be passed without encountering major resistance. Spaces other than the vascular system, such as in the urinary and biliary tract (especially if dilated), can be percutaneously entered for study and therapeutic maneuvers. Lesions such as abscesses, urinomas, or bilomas also fulfill the necessary physical requirements, so one can catheterize them and institute drainage. As experience has been gained with these catheterization methods, they have found wide application in the field of oncology.

Advances in imaging, such as high quality image-intensified fluoroscopy, ultrasound, and CT, have made it possible to exquisitely localize spaces and masses within the body and readily determine whether there is a path for a percutaneous approach. If a safe route is present, one can percutaneously perform a biopsy on a mass, drain a space, or embolize a vessel to retard tumor growth or to achieve hemostasis.

We would like to present an overview of the application of interventional radiology to the field of cancer. This is based on reports in the literature and the extensive experience of the Angiography and Interventional Radiology Section at the University of Wisconsin.

Vascular interventions

Vascular interventions in cancer treatment have centered around selective catheterization of arteries for the direct infusion of chemotherapeutic agents or embolization of vessels feeding tumors to induce necrosis or stop bleeding.

Selective catheterization of the arterial supply of a tumor allows the delivery of high concentrations of chemotherapeutic agents with a reduction in the total dose required for therapy. The risk of systemic toxicity is thereby decreased. The technique has been known for more than 25 years, but there appears to be less enthusiasm for it currently. At present, when the technique is used, surgically introduced catheters with implanted infusion pumps seem to be more in vogue than percutaneously placed catheters. The advantage of the infusion pump is that it is less cumbersome for the patients, and since it is implanted the possibility of infection at the skin site is virtually eliminated. It generally requires, however, that the patient have a laparotomy for placement of the catheter. In addition, the positioning of the catheter is much less controlled than by radiological methods. It would seem that the advantage of the percutaneous approach, which would avoid laparotomy and allow better placement of the catheter, could be

combined with the implanted pump by burying the external end of the percutaneous catheter. We are somewhat perplexed why this combination has not been adopted.

At the present time, the interest in selective intraarterial infusion therapy seems to be at a nadir. The two major institutions advocating this type of treatment are the M.D. Anderson Hospital in Houston and Emory University in Atlanta.

Reduction of blood supply to a tumor as a primary therapeutic modality or as a preoperative maneuver to reduce blood loss at surgery has been advocated by some. In the central nervous system and peripherally local sarcomas, the arterial supply can be selectively catheterized and embolized with particulate matter, detachable balloons or coils. Within 24 hours, surgery is carried out with reduced blood loss because the vascularity will be decreased and insufficient time will have elapsed to allow the development of a substantial collateral network. In the kidney, preoperative injections of particulate matter have been done, with surgery being conducted under similar circumstances. Such embolizations are usually reserved for very extensive tumors or cases in which the renal vein or vena cava is invaded.

The injection of agents that will introduce coagulation rather than ischemic necrosis is useful. The chemical most often used for this purpose is ethyl alcohol. Alcohol rapidly causes cell disruption, protein denaturation, and changes in the endothelium with plugging of vessels. A combination of coagulation and ischemic necrosis results. Alcohol has an advantage in that if it should pass through an arteriovenous communication into the venous system, it is rapidly diluted. Under these circumstances, we have a chemical with which man has extensive experience, particularly when it has been administered orally.

In addition to preoperative treatment, the induction of necrosis by transvascular manipulation of nonresectable neoplasms may provide substantial palliation. Rather large metastatic deposits or primary lesions of the appendicular skeleton, bony pelvis, and spine have been satisfactorily treated this way. Recalcification of the involved bone is common. The reduction in tumor burden secondary to embolization may be advantageous in that the decrease in overall mass may lessen the patient's discomfort. Problems such as calcium imbalance, which may be seen in some tumors, may be reversed. Lunderquist, from the University of Lund, and Allison, from Hammersmith Hospital, have reported control of the symptoms of carcinoid syndrome by embolizing the metastatic foci in the liver with Gelfoam slurry. Control of the patient's symptoms has been excellent, and while they will generally recur within 12 months re-embolization may be carried out and the symptoms will again be ameliorated. They have reported a large number of patients who have received substantial benefit from this approach.

Our most extensive experience with transvascular treatment of neoplasms has been with recurrent gynecological tumors that have caused copious vaginal bleeding. The approach is to selectively catheterize each of the anterior trunks of the hypogastric arteries and then to embolize them with large particles of Gelfoam or Ivalon. This appreciably reduces the blood supply of the tumor, and in most circumstances the bleeding will be reduced or stopped. Because of the extensive collateral circulation to the normal pelvic organs, necrosis of the bladder or rectum with the use of particles is very unusual. The bleeding is generally controlled for three to six months, and should it recur, re-embolization can be carried out. Since most of these patients have relatively advanced disease, most will have died before the bleeding recurs.

Venous disease

Venous obstruction secondary to the direct involvement by a neoplasm is common. Generally, therapy under these circumstances is directed to the tumor mass. On the other hand, spontaneous thrombosis, particularly in the lower extremities, is frequently seen in patients with tumors. As a rule, anticoagulation therapy is the preferred treatment. In patients in whom peripheral or pelvic venous thrombosis has resulted in pulmonary embolism despite anticoagulation therapy or in those patients in whom anticoagulation therapy is contraindicated, interruption of the inferior vena cava should be considered.

In the past, the approach was surgical with the placement of a clip or multiple sutures through the inferior vena cava. More recently, through surgically created venotomies, various filters have been placed. At the present time, it is possible to insert these filters percutaneously. This avoids the need for an incision for the venotomy, which is usually done under general anesthesia. The percutaneous results are comparable to surgery, and the attendant simplicity makes this a very attractive procedure.

Obstruction of the superior or inferior vena cava, either spontaneously or because of various catheters that are being used for hyperalimentation or chemotherapy, is a common problem. The thrombosis itself may result in major discomfort for the patient and may preclude the use of this route for infusion of nutritional or therapeutic solutions. The use of systemic lytic therapy may result in the lysis of some of these thromboses. Where practical, however, use of a catheter to deliver the lytic agent directly into the clot allows for higher concentrations in the area of interest and a decreased risk of systemic complications. Balloon angioplasty may be useful in combination with lytic therapy.

We are currently using urokinase infused through a catheter that has been imbedded in the clot. We are

very encouraged by the substantial benefits that have accrued for some patients. As we have gained more experience and become more aggressive, the clots with which we are dealing are fresher and the likelihood of a good result is increasing. The use of urokinase, which is nonantigenic, has eliminated the problem of antibodies to streptokinase secondary to previous streptococcal infection. In addition, urokinase is much less likely to result in bleeding complications. Increased use of this technique is likely in the near future.

Drainage procedures

Urinary and biliary tract. Obstruction of the urinary or biliary tract by either primary or secondary tumors is frequently encountered. Such obstruction may result in marked biochemical abnormalities, and frequently sepsis will supervene. Usually dilation of the urinary or biliary tract proximal to the obstruction will occur. Such dilation simplifies percutaneous entry into the system. Puncture of the renal collecting system is carried out under ultrasonic control. Access to the biliary system is generally via a lateral approach to the right system with fluoroscopy. If desired, the left system can be catheterized from the front with ultrasonic guidance.

Once the system is entered with a small-caliber needle, some urine or bile is aspirated, and a small amount of radiopaque contrast agent is injected to delineate the pathologic anatomy. Then a Seldinger exchange may be made and a catheter placed within the obstructed system. If there is not an abnormality of the liver or kidney per se, diversion of the obstructed system will result in correction of the biochemical problem. Drainage with concomitant antibiotic therapy generally will clear any infection that is present.

External drainage may be very satisfactory in correcting some of the patient's problems, but it is optimum not to have external drainage into a bag. If therapy directed at the tumor, whether surgery, radiation or chemotherapy, does not restore patency of the obstructed tract, a catheter may be passed through the obstruction and restore internal drainage. Guide wires are passed through the obstruction and then stents, which will have holes proximal and distal to the obstruction, are placed. If the external port is closed, the pressure in the proximal system will be such that the bile or urine will be forced into the stent down through the area of obstruction and egress through the holes distal to the obstruction, with are either in the bladder or the duodenum. Competitive with these techniques is the placement of stents retrograde under endoscopic control from the bladder or the duodenum.

Most patients who require such diversion or stenting have relatively advanced disease, and a long-term prognosis is poor. Nevertheless, we have had one patient with a cholangiocarcinoma who was satisfactorily palliated over four and one-half years, and we have a large number of patients who have had urinary diversions for over three years. We have been very impressed that the use of these techniques has afforded substantial palliation to a large number of patients.

Drainage of abnormal collections. Abnormal collections such as abscesses, urinomas and bilomas are frequent occurrences in oncology patients. Treatment is generally directed to drainage and, if necessary, correction of the urinary biliary or gastrointestinal leaks. Urinary or biliary diversion of stenting described above, in combination with percutaneous drainage of a biloma or urinoma, will be satisfactory for control of the condition in most instances.

Percutaneous drainage of intrahepatic and intra-abdominal and retroperitoneal abscesses has become the preferred treatment. If free communication with the gastrointestinal tract does not exist, percutaneous drainage and appropriate antibiotic therapy will result in clearing of over 90% of abscesses. In those instances where surgical therapy is required later, the patient is generally in better condition, and, therefore, a more definitive procedure, eg, bowel resection, may be possible.

Book review

Manual of Clinical Hematology, edited by Joseph J. Mazza, MD; a Little Brown Publication—Spiral Manual Series

This manual covers the diagnosis and therapy of common hematologic disorders including leukemias, disorders of the lymph nodes, bleeding disorders, anemia and the platelet disorders. The concise descriptions of these and other hematologic disorders cover important pathophysiologic information as well as clinical recommendations. Discussions of selecting, ordering and reading laboratory tests will be of continual practical use to every clinician. Clear, uncomplicated illustrations and diagrams accompany the test. References following each chapter emphasize review articles that will be useful in the diagnosis and treatment of the hematologic patient.

The Manual of Clinical Hematology is a practical review and primer that provides the essentials needed on the ward by students and physicians.—*RDS*

Wisconsin physicians who have written books are encouraged to submit their works for review in the *WMJ*. Contact: Book Reviews, Wisconsin Medical Journal, PO Box 1109, Madison, WI 53701.■

Percutaneous gastrostomy. Surgical gastrostomy for long-term feeding in patients with esophageal or cardioesophageal junction obstruction is a well-known procedure. Recently, techniques for establishing gastrostomy percutaneously with either fluoroscopic or endoscopic control have been developed. The percutaneous method has two advantages over the endoscopic one. It can be performed in cases when the endoscope cannot be passed due to total obstruction of the esophagus. In addition, it may be possible to pass a feeding tube from the stomach distal to the ligament of Treitz. This will obviate gastric distension as well as reflux into the esophagus, an event that may be quite uncomfortable for the patient. Complications of the percutaneous technique are quite low, it is performed under local anesthesia, and gratifying palliation may be achieved.

Percutaneous biopsy

Currently, with high resolution image intensification fluoroscopy, ultrasound and CT, either primary or secondary masses are readily identified in patients with known or suspected tumor. In some circumstances, it is appropriate to have these masses approached surgically so that definitive therapy can be carried out simultaneously with a biopsy. Other masses may be located such that a percutaneous biopsy would be inadvisable. On the other hand, in a wide variety of situations, a percutaneous biopsy can ascertain whether a mass is a neoplasm, and in most cases, the cell type can be determined. Extensive experience with percutaneous needle biopsy of masses has shown that seeding along a biopsy tract is an exceedingly rare event so that it need not be considered as a contraindication to this approach.

Biopsy of most pulmonary masses is done under fluoroscopic control with an 18-, 19-, or 20-gauge needle. The two common complications are hemoptysis and pneumothorax. A minor amount of blood-tinged sputum is frequent and is generally not a problem. Major hemoptysis is very unusual. Pneumothorax is much more common and is directly related to how aggressive one is in approaching pulmonary masses. If small, deeply situated nodules are routinely subjected to a biopsy, one may expect a pneumothorax rate of 30% to 50%. On the other hand, if large masses involving the chest wall constitute the majority of patients, a pneumothorax rate in the range of 5% or less may be more in order. It should be kept in mind that the pneumothorax rate for thoracotomy is 100%.

Most of the pneumothoraces are self-limited and do not require therapy. Should treatment be necessary, a small caliber percutaneous catheter is inserted and attached to a Heimlich, one-way valve. Most of these pneumothoraces will resolve within 24 hours.

We routinely carry out thoracic biopsies in patients with good pulmonary reserve on an outpatient basis and only admit those patients who develop a significant pneumothorax. Generally, these admissions do not exceed 24 hours.

Under ultrasound or CT control, biopsies of deep-seated masses in the liver, retroperitoneum, abdomen, spine, pelvis, and extremities can be readily carried out, usually on an outpatient basis. Needless to say, candidates for percutaneous biopsy must have normal coagulation parameters. In properly selected patients and lesions, one can anticipate positive information in over 90% of biopsies.

General considerations

The major advantages of the percutaneous techniques for patients with tumors are that the procedures can usually be done with local anesthesia and analgesia, they are much less taxing on the patient, and they are less expensive. In some instances —eg, biliary bypass—it may be possible to perform a percutaneous procedure when surgical or endoscopic bypass cannot be carried out because of the extent of disease or the condition of the patient.

On the other hand, one must be wary that the ease with which percutaneous procedures can be performed may lead to inappropriate use. Is it necessary to perform a biopsy on all masses in patients with known tumor to prove that metastases are present? Because we can easily treat obstructive uropathy percutaneously in patients with advanced malignancy, should we always do it? Such bypass may result in a prolongation of life of questionable quality only to have the patient die painfully of metastatic disease. While interventional radiology represents a major advance in the science of medicine, its use requires meticulous attention to the personal, social, and ethical aspects of patient care.

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Clinical cancer: 27

The psycho-social aspects of cancer

Edward Prendergast, MD, Madison

BESIDES THE DISRUPTION of their physiology, patients with cancer have a disruption of their entire lives. For some patients, coping with this damage may be more difficult than dealing with the physical symptoms and discomfort cancer brings. Our efforts to care for these patients must encompass not only the physical problems, but the social, psychological and financial ones, too.

Patients living with cancer

Among the first needs of patients with cancer is information. From the time the diagnosis is made, a patient and his or her family require knowledge about the nature of the disease and its treatment. Most of this will be provided by the physicians and nurses caring for the patient. Two other excellent sources are the Cancer Information Service and the American Cancer Society.

The Cancer Information Service in Wisconsin (1-800-4CANCER), a toll-free number available to anyone requiring information about cancer, will answer questions, provide brochures and other materials, and provide information on services available throughout the state.

The American Cancer Society (608-249-0487) has its main office in Madison, and area offices are located throughout the state. The ACS can provide detailed educational literature concerning the various types of cancer, cancer treatments, and prevention. The ACS also sponsors several educational and self-help group services. One such service, I Can Cope, is aimed at cancer patients and anyone touched by the disease such as a spouse, family, or friends. In eight sessions, taught by health-care professionals, the participants learn about their disease, side effects of treatment, and nutrition. There are also discussions of feelings and communication, self-image and sexuality, and living with limitations. Participants are also introduced to representatives of community agencies who describe their services.

Cancer patients also need financial and vocational help. County social service departments can provide medical assistance, general assistance, food stamps, home care funding, and aid to families with dependent children. The Social Security Administration provides financial assistance to elderly and handicapped persons. For veterans, a local veterans service officer can provide information about assistance. The state Division of Vocational Rehabilitation assists with physical, psychological, and educational rehabilitation. To be eligible, patients must have a physical or mental disorder that constitutes a substantial handicap to competitive employment.

Many cancer patients require assistance in the tasks of day-to-day living. Families and friends provide much of this help, but some patients are socially isolated or may require special assistance. Each Wisconsin county has a home care agency, which can be reached through the county social services department. The Visiting Nurse Service provides care in the home, home health aides, and physical, occupational, and speech therapy. Another program, Meals on Wheels, is available in many urban areas to provide nutritional support.

Transportation can be a major obstacle for cancer patients, and the American Cancer Society can sometimes provide volunteers to take people to physician appointments and radiation therapy. Many communities have recruited volunteers to perform this service; for information contact the local hospital's social service department.

Equipment for cancer patients can be quite expensive and may not be covered by insurance plans. The local ACS office often will lend equipment such as hospital beds, walkers, and wheelchairs free of charge, and some can even provide wigs. Veterans of Foreign Wars posts throughout the state also have loan closets, and a patient does not need to be a veteran to use their equipment.

Both the cancer patient and the family may seek psychological and emotional support services. Such services can be a great boon to everyone by breaking down isolation and allowing them communication with others who have similar problems. The participants also can trade solutions and provide mutual emotional support. Make Today Count and Living With Cancer are support groups sponsored by the ACS that meet regularly to discuss problems and share experiences. The goal is to help each other learn to live with cancer. The ACS also sponsors support groups for specific disease and treatment-related problems. These include the Ostomy Association, the Laryngectomy Group, and Reach to Recovery. The local or state ACS office can provide information on the availability of services in particular areas of the state.

Patients dying with cancer

As patients weaken, their need for home care increases. Frequently, they need special attention for pain control and the alleviation of other symptoms. For the patient's family, the grieving process begins before death, and they

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can greatly benefit from the counsel and support of a sensitive physician and other health-care workers. It is at this stage that house calls by physicians have great practical and symbolic meaning for patients and families.

There is now more help available to physicians who care for cancer patients approaching death. The hospice movement, which began in Great Britain and has spread widely through the United States, has helped focus attention on the problems faced by dying patients. Available in many, but not all, Wisconsin counties, hospice programs offer home care assistance and evaluation of pain and symptom control plans. The hospice staff can coordinate help from volunteers and the patient's natural support systems such as friends, neighbors, and fellow church members, and they have a particular interest in providing support during bereavement to patient's families. Hospice volunteers may also provide respite for family members, light housekeeping, child care, and meal preparation. Many hospice programs are covered by Medicare; private insurance may also pay for these services. Since they are community supported, fees may be reduced or eliminated for needy patients.

Patients surviving cancer

Fifty percent of all cancer patients are alive after five years, and the bulk of these are cured in the sense that the cancer will not recur. They may, however, have many problems from their experience with the disease.

Cancer survivors do not appear to have a higher incidence of psychiatric disorders, but less severe emotional difficulties are fairly common. Many patients feel a chronic uncertainty; for them, the sense of invulnerability that we all carry is shattered and it can never completely be put back in place. Small events in life (eg, reading a certain magazine article or passing the hospital) repeatedly remind a patient that he or she faced death. Most patients try to cope by acting as if the disease is truly behind them, healthy denial so to speak. Occasionally, patients try to deny completely the illness and its impact. This may lead to missed medical appointments, continued smoking, ignoring of symptoms, or other behaviors that are potentially dangerous. Some patients, on the other hand, worry that common physical symptoms herald a recurrence of their disease. A cough or a joint pain suddenly raises the specter of cancer again. This hypervigilance usually slowly diminishes with time, but can be quite distressing to some, who even become worried about being worried. Reassurance that this reaction is common can relieve them a great deal.

Changes in body image are very important to cancer survivors. Besides the obvious examples of mastectomy and head and neck cancer victims, even those with no visible signs of their disease may feel "damaged." Their self-esteem and sense of self-worth may be changed. Interestingly, a few cancer survivors report feeling special and powerful, with a sense of having vanquished a threatening foe.

The place of the cancer survivor in his or her family may also be a source of conflict. Adjustments are required as the survivor resumes his or her role as a well person. Occasionally, protective family members try to keep the patient in a restricted status. At the other extreme, patients may be pushed to resume normal status before they are capable of it. The transition does not always go smoothly.

The physician's role in helping the cancer survivor is to be sensitive to potential problems and be available to discuss them. Referrals to outside help may be necessary, but often reassurance about the "normalness" of psychosocial problems can be the most comforting.■

Wisconsin Clearinghouse

The Wisconsin Clearinghouse is a state agency for information on alcohol and other mood-altering drugs, primary prevention, mental health and other health topics.

Housed at the University of Wisconsin–Madison, the Clearinghouse offers many publications which are suitable for patient information, as well as for professional reference. Dozens of these are available at no cost to Wisconsin residents, except for shipping and handling, and a separate catalog lists more than 30 other publications available for purchase.

Some publications are produced by the Clearinghouse staff, while others are provided by the Wisconsin Office on Alcohol and Other Drug Abuse, the National Institute on Drug Abuse, the Addiction Research Foundation and other organizations.

In addition to pamphlets, books, professional manuals, public awareness kits and curricula, the Clearinghouse offers many colorful posters designed to appeal to people of many ages and interests. Also available are video tapes on marijuana, caffeine, and the dangers of chemicals unknown to children.

The Clearinghouse staff also evaluates films and publications from other sources. Synopses, ratings and other information on these resources are available on request.

Wisconsin Clearinghouse office hours are 8:30 am to 4:45 pm, Monday through Friday. Publications can be ordered by mail or phone. For more information, contact the Wisconsin Clearinghouse, Dept MJ, PO Box 1468, Madison, WI 53701 (608-263-2797).■

Special

Abortion, euthanasia and the Malthusian theory

George W. Kindschi, MD, Monroe

THE QUANDARY CREATED by the ethical dilemma of abortion and euthanasia has been approached from many different directions. Many people—including philosophers, ethicists, moralists, and physicians—have expressed opinions based on their own value systems. Many, if not all, of these arguments are clouded with the emotions of their authors, and, as I read and listen, I become acutely aware that it is difficult, if not impossible, to address these two subjects objectively, either through the reality of case studies, the horror of Auschwitz, or the sanctity of the philosopher's study. Abortion and euthanasia are inexorably linked to the thread of human emotion, and separation from this thread only promotes futile arguments and engenders meaningless conclusions.

There is, however, a reality that looms on the horizon that may bring these emotional arguments into sharper focus, forcing on us a decision for which no one is now prepared and possibly for which no one can ever be prepared. The identification of this situation dates from 1798 and comes from the succinct works of Thomas Malthus: ". . . if the same quantity of land was employed in their (potatoes) culture as is now employed in the culture of corn, the country would be able to support a much greater population, and would consequently in a very short time have it."[1]

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Malthus envisioned a world overrun with people who were constantly on the verge of starvation. He believed that famine was the last and most dreadful resource of nature. The future poses far greater problems than just famine, for, by extending the Malthusian thought, we may speculate that sometime in the future we will reach the limits of all the resources of this planet. These resources include not only food but energy, raw materials, fresh water, living space, and even the air we breathe. Already the effects of limited energy, restricted food, and diminished pure water supplies are being felt in some areas of the world.

What then the ethical dilemma of abortion and euthanasia? How can civilization cope with an increasing population faced with decreasing resources? How will it feed and educate the children, and how will it care for the aged and infirm? Will the time come when, out of the necessity for the survival of the species, someone must decide who will live and who will die?

Before we can truly deal with this problem, we must be able to answer the following question: Is it (the fetus, or the as-yet unborn and underdeveloped child) *already* a person?[2]

The arguments on this question are heated and emotional; seemingly arbitrary and quasi-scientific criteria have been applied, but no accurate, widely acceptable definition of the actual beginning of personhood has been forthcoming. Traditionally, either conception or birth have been the accepted points of this beginning. The latter is analogous to the sprouting of a seed or the hatching of an egg. In the former, it is the combination of the correct genetic material which, over a period of time, will produce an adult organism. Which of these should we accept as correct? It makes a great deal of difference to the fetus.

The quandary we are in seems to stem partly from our multi-level value system. We value the sanctity of life, yet we value the rights of the individual. We value our freedoms as well as our commitments to the welfare of others. It seems that the statements about "survival outside the womb" and the judicial "28-week decision" have done more to stir up the already muddied waters than they have to settle the issue. The growth and development of the human from zygote to adult is accepted by most as a continuum, with the development of personhood being a gradual thing. To actually define what is human and what is going to be human is apparently not yet within our grasp. We are forced, therefore, to make arbitrary decisions—unsatisfactory arbitrary decisions.

The issue of "rights" is just as clouded and seems to be just as arbitrary as the issue of "when is it a person?" During gestation, what rights—if any—does the fetus have over and above the rights of the woman? At the same time, what responsibilities—if any—does the woman have to the fetus? Ultimately, what responsibility do any of us have toward the fetus if the presence of the new person will endanger the survival of the human species?

At one extreme there are those who state that the woman's rights over her body are abrogated at the time of conception, and that the life of the fetus is paramount. At the other extreme there are those who believe that even immediately after birth the infant is not a person and that infanticide within the first few weeks is not murder.[3] There are an infinite number of beliefs between these two poles, and there is no consensus.

Similar problems exist on the subject of euthanasia: Is it (the person in question) *still* a person?[2]

Without an accurate definition of when a person is still a person, the threat that was created in German mental hospitals during 1938–1945 will be with us forever.

Richard Trubo, in his 1973 book on euthanasia,[4] gives the following account: ". . . 275,000 'incurable' mental patients were killed from 1938 to 1945 in Germany. The object was 'the destruction of life devoid of value.' These were not incurable patients but were superfluous people —'useless eaters,' undesirables—the identification and elimination of the weak . . ." The principles of mass killing were then applied to other "undesirables," and millions died.

Yet, as we look at the nursing homes, the mental hospitals, the cancer wards, and the homes for the severely handicapped, we begin to realize the vast amount of medical resources consumed in the care of these patients—people who will never again be able to contribute to society or have never been able to make any kind of contribution to society. The pangs of futility may lead some observers to think, "Why should their agony be prolonged? Why should the decerebrate patient be treated for pneumonia, the agonal patient continue to receive chemotherapy, or the hydrocephalic with the coordination and mentality of a 6-month-old child be supported, treated, and preserved when these resources could be used to treat productive people?"

The problem is similar to one faced by military physicians during World War II. They had a choice to use the then-scarce penicillin either to treat venereal disease and send a soldier back to the front, or use it to fight an infection in a wounded soldier who would not only never fight again, but who might not live.

The agony of keeping seemingly nonpersons alive would not be a problem if they were house pets: they would be put out of their misery—put to sleep. With humans, however, the ground rules are much, much different. To "put them out of their misery" would be euthanasia, and euthanasia is murder.

Finally, if we take these arguments and carry them to their logical extremes, there are but two outcomes: the anti-abortion groups must be ready to support a burgeoning population of the elderly, the retarded, and the handicapped, since they, too, have a right to life as great as any fetus. The pro-abortion groups must be ready to support euthanasia of the terminally ill, the incurable, and those who are the "useless eaters" of our society. Which group is correct?

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Procainamide induced lupus anticoagulant

Marie T. Weber, MD, and William G. Hocking, MD, Marshfield

Abstract: A patient with procainamide-associated lupus anticoagulant is described, and the relationship of this and other antiphospholipid antibodies to late coronary graft occlusion and myocardial infarction reviewed.

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ALTHOUGH the lupus anticoagulant originally was reported to be associated with bleeding, these antiphospholipid antibodies are now known to be associated primarily with thrombosis, thrombocytopenia, and recurrent fetal loss.[1] Anticardiolipin antibodies (ACA), a related type of antiphospholipid antibody, have recently been associated with both myocardial infarction and coronary artery graft occlusion. The lupus anticoagulant has been reported in patients with procainamide-induced systemic lupus erythematosus.[2] We report a case of procainamide-associated lupus anticoagulant and discuss the relationship of this and anticardiolipin antibodies to late coronary graft occlusion and myocardial infarction.

Case report

In August 1980, a 57-year-old man came to our clinic complaining of chest pain on exertion. His cardiac risk factors were hypertension, obesity, and a family history of premature atherosclerosis. The patient's condition was managed with drugs until June 1981, when he developed crescendo angina. Coronary angiography revealed severe triple vessel disease, but normal left ventricular function, and he underwent triple vessel coronary bypass grafting. The postoperative course was complicated by premature ventricular beats and short runs of ventricular tachycardia. The patient was placed on procainamide hydrochloride tablets (Procan SR) two grams per day.

He was free of symptoms until April 1987 when he experienced near syncope precipitated by acute inferior myocardial infarction. Following this, he had progressive dyspnea on exertion and was referred for reevaluation. Preadmission testing revealed a partial thromboplastin time prolonged to 69.2 seconds and a prothrombin time prolonged to 14.1 seconds, both confirmed on repeat testing. In 1981, these tests had been normal. Fibrinogen level, thrombin time, protamine sulfate, and fibrin split products were normal. Mixing studies revealed incomplete correction with citrated normal plasma but no further prolongation with incubation. The tissue thromboplastin inhibition was abnormal at 1:1000 dilution with a ratio of 2.6. In the platelet neutralization procedure, the partial thromboplastin time corrected to 33.2 seconds. Anticardiolipin antibody IgG levels were five standard deviations and IgM levels 13 standard deviations above the mean of controls. Antinuclear antibody was positive at greater than 1:640 with a homogeneous pattern. Procainamide-induced lupus anticoagulant was presumptively diagnosed and the procainamide discontinued.

Cardiac catheterization revealed progressive disease in the native coronary arteries and obstruction of the graft to the posterior descending right coronary artery. He was placed on aspirin and dipyridamole. At one-month follow-up, he was still experiencing dyspnea on exertion. Stress thallium revealed a fixed defect in the inferior wall of the left ventricle, but no exercise-induced ischemia. Partial thromboplastin time was still prolonged to 54.0 seconds. The prothrombin time had returned to a normal value of 12.9 seconds. Follow-up tests in December 1987 revealed that the partial thromboplastin time was continuing to improve, but still prolonged at 40.0 seconds. The tissue thromboplastin inhibition was also improved, but still abnormal at 1.9 at 1:1000 dilution. No IgG anticardiolipin was detected, but the IgM anticardiolipin antibody was still noted to be present at 4.4 standard deviations above the mean of controls.

Discussion

Antiphospholipid antibodies have been associated with a variety of thrombotic problems. Several hypotheses have been proposed to explain the thrombotic predisposition. The lupus anticoagulant inhibits prostacyclin production by endothelial cells.[3] Prostacyclin inhibits platelet aggregation and is a potent vasodilator. Decreased prostacyclin activity may increase platelet aggregation. The lupus anticoagulant interferes with the interaction among thrombin, protein C, and thrombomodulin on endothelial cell surfaces,[4] which may reduce the rate of protein C activation. Antiphospholipid antibodies bind platelet membrane phospholipids causing platelet activation that may result in increased platelet aggregation.[5] Finally, the lupus anticoagulant inhibits prekallikrein generation, which may impair conversion of plasminogen to plasmin and interfere with contact activation of the fibrinolytic system.[6]

Recently, elevated anticardiolipin antibody levels have been associated with recurrent thrombotic complications following acute myocardial infarction in patients less than 45 years old.[7] Twenty-one percent of the patients were ACA-positive on two or more occasions, and among those patients, 60% experienced subsequent thrombotic events, compared to 25% of the ACA-negative patients. Elevated preoperative anticardiolipin antibody levels have also recently been associated with an increased risk of late graft occlusion following coronary artery bypass surgery.[8] Patients with previous myocardial infarction had an enhanced anticardiolipin antibody response, suggesting that coronary artery surgery provokes an amnestic response in patients previously sensitized to cardiolipin.

The antiphospholipid antibodies in our patient may have resulted from procainamide use or from sensitization to cardiolipin during bypass grafting. Procainamide-induced lupus anticoagulant has been reported, but not in the setting of myocardial infarction.[9-11] These antibodies coupled with atherosclerosis may have led to late coronary graft occlusion with the resultant myocardial infarction provoking an amnestic response. The patient is being treated with antiplatelet therapy and has not experienced subsequent thrombotic complications despite persistence of anticardiolipin antibodies and lupus anticoagulant.

The role of antiphospholipid antibodies in myocardial infarction and cardiac surgery needs further study. It is not clear whether antiphospholipid antibodies are an independent prognostic factor in patients with myocardial infarction. Consideration might be given to monitoring cardiac patients for the presence of antiphospholipid antibodies because they place the patient at a higher risk for recurrent cardiovascular events. Intervention with anticoagulant or antiplatelet therapy may be beneficial in patients with antibodies. It is not known if drug-induced antibodies carry the same risk as those that develop de novo or after cardiac surgery or myocardial infarction. The use of

immunosuppressive therapy to avoid sensitization to cardiolipin during myocardial infarction or cardiac surgery may be another consideration.

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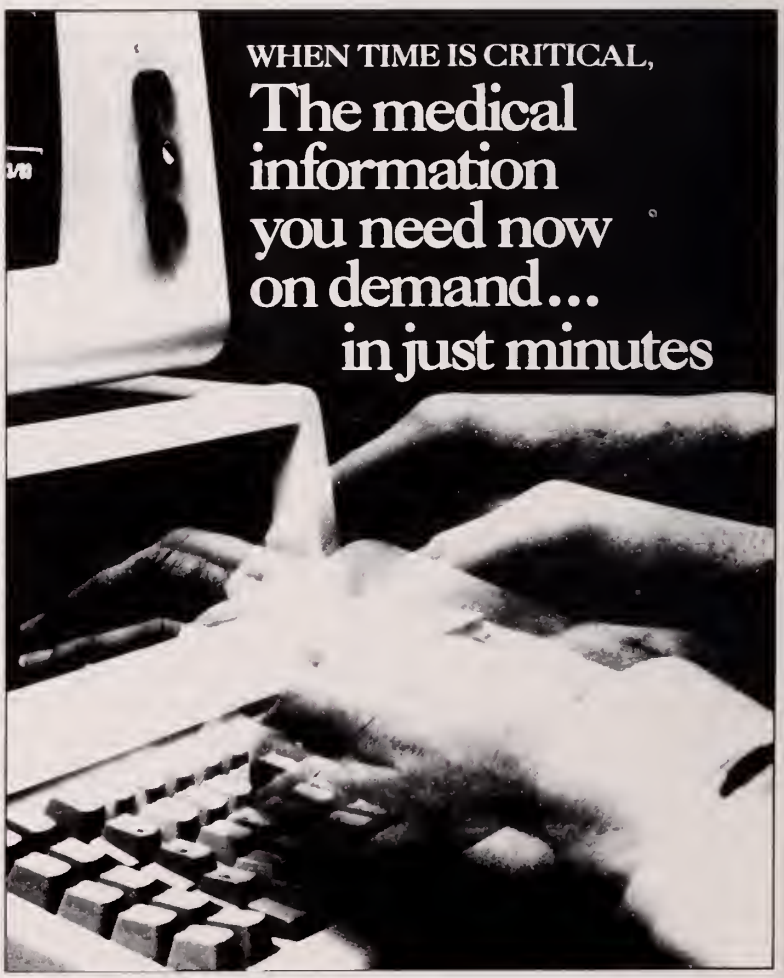

Loss prevention corner

The costly oversight

Webster defines oversight as an unintentional omission or mistake, but in our context it can be defined as the failure to investigate and diagnose a symptom or abnormality.

Case study 1

After surgery, a hospitalized patient developed a fever, and pneumonia was suspected. The chest x-ray was negative for pneumonia, but did indicate a possible nodular density. Tomograms were taken, and the radiologist thought the nodular density was benign and suggested a follow-up.

A year later, the patient was diagnosed as having terminal lung cancer. When, prior to his death, the patient learned of the earlier x-ray diagnosis and recommendation for follow-up, he filed suit for the failure to make an early diagnosis. The defendant attending physicians claimed the patient had been informed of his condition, but there was no documentation of this in the patient's chart. This case in Oklahoma was settled for $90,000 after the patient's death.

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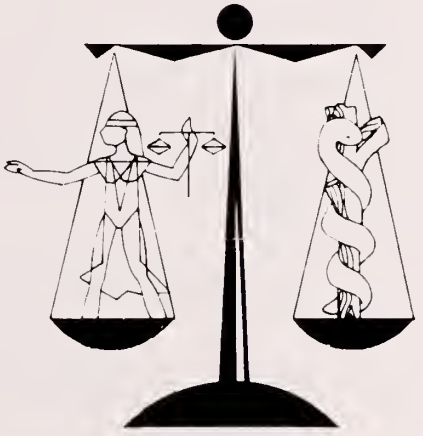
What were the oversights in this case? First, a positive x-ray finding and recommendation for follow-up was overlooked by the attending physicians. Incorrect handling of an unexpected positive finding on an x-ray or laboratory report is a common pitfall which can be avoided with appropriate safeguard systems in the hospital and the office.

Second, if the physicians had discussed this finding with the patient, as they said they did, then they overlooked the need to document the discussion in his chart.

A number of suggestions arise from this case:

- Make certain that all positive findings are brought to the doctor's attention, either by a phone call from the consultant or by flagging the report. In the office, the physician can establish the policy that no report is to be filed in the chart until he or she has initialed it.
- Flag conditions which call for a follow-up. Either flag the patient's chart or create a "current problem" list.
- Ask your staff to alert you. For each office visit, your staff should review the patient's chart and alert you to any conditions noted in previous visits that require a follow-up. Document any change, need for investigation or further follow-up.
- Document discussions of positive findings with patients. A malpractice jury is unlikely to believe that you discussed something with the patient if there is no documentation in the chart.



Case study 2

The patient was being seen in a Naval Family Practice Clinic for a persistent cervical lesion. The allegations were that the physicians failed to properly perform a biopsy on the lesion, or to perform a subsequent biopsy. In addition, the patient did not have a PAP smear for 18 months, which violated the clinic's policy of annual PAP smears for asymptomatic patients.

By the time the cervical cancer was finally diagnosed, the spread of the disease was such that a hysterectomy was no longer a sufficient treatment. The patient was, therefore, treated with radiation, which resulted in extensive retroperitoneal fibrosis in the ureters and intestines, ureteral obtructions and ultimately the loss of a kidney.

What was the oversight? Because cervical cancer is curable if diagosed early, the failure of a physician to perform PAP smears at appropriate interals, or noncompliance with an established policy, is very difficult to defend.

Two suggestions here are:

• Rule out cancer. Whenever a patient has a symptom which could be indicative of cancer, it is crucial for each health care provider to confirm or rule out the presence of a maligancy. In today's liability environment, a wait-and-see attitude is the most dangerous to take.

• Establish, and ensure compliance with, screening policies. It is appropriate to have PAP smear and other screening policies. These policies should ensure that a patient is not missed in a procedural oversight.■

AMA Awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

MAY 1988

*Danforth, R. Clarke, Milwaukee
*Dean, Russell Allyn, Greenwood
*Dyer, Richard K., Manitowoc
*Gahl, Robert A., Two Rivers
*Garber, Bradley G., Fairchild
*Gehring, John V., Green Bay
*Gruesen, Robert A., Marshfield
*Handler, Bruce, La Crosse
*Hoy, Edward J., Watertown
*Johnson, Steven J., Prairie du Sac
Koepsell, James D., Milwaukee
Landay, Stuart P., Madison
*Levin, Jules D., Milwaukee
Lloyd, Maryann E., West Allis
*Matzke, Rudolf W., Spooner
*Merlis, Anthony L., Madison
*Montemurro, Angelina M., Kenosha
*Nordholm, Vincent W., Stoughton
*Norman, Stanley G., Eau Claire
*Oujiri, John C., Ashland
*Pawlak, James R., Cleveland
*Roehmholdt, John M., Madison
*Saarinen, David M., Ashland
*Sulas, Leonas P., Portage
*Thompson, Teddy L., La Crosse
Welter, Timothy M., Marshfield
*Williamson, Warren H., Racine■

America's worries

The cost of medical care is second on the list of Americans' biggest worries, according to a survey by Nation Family Opinion, Inc. Drug abuse finished No. 1 and the federal budget deficit came in third. The top ten was rounded out by unemployment, crime, loss of manufacturing jobs, alcoholism, the plight of American farmers, AIDS, and poverty.■

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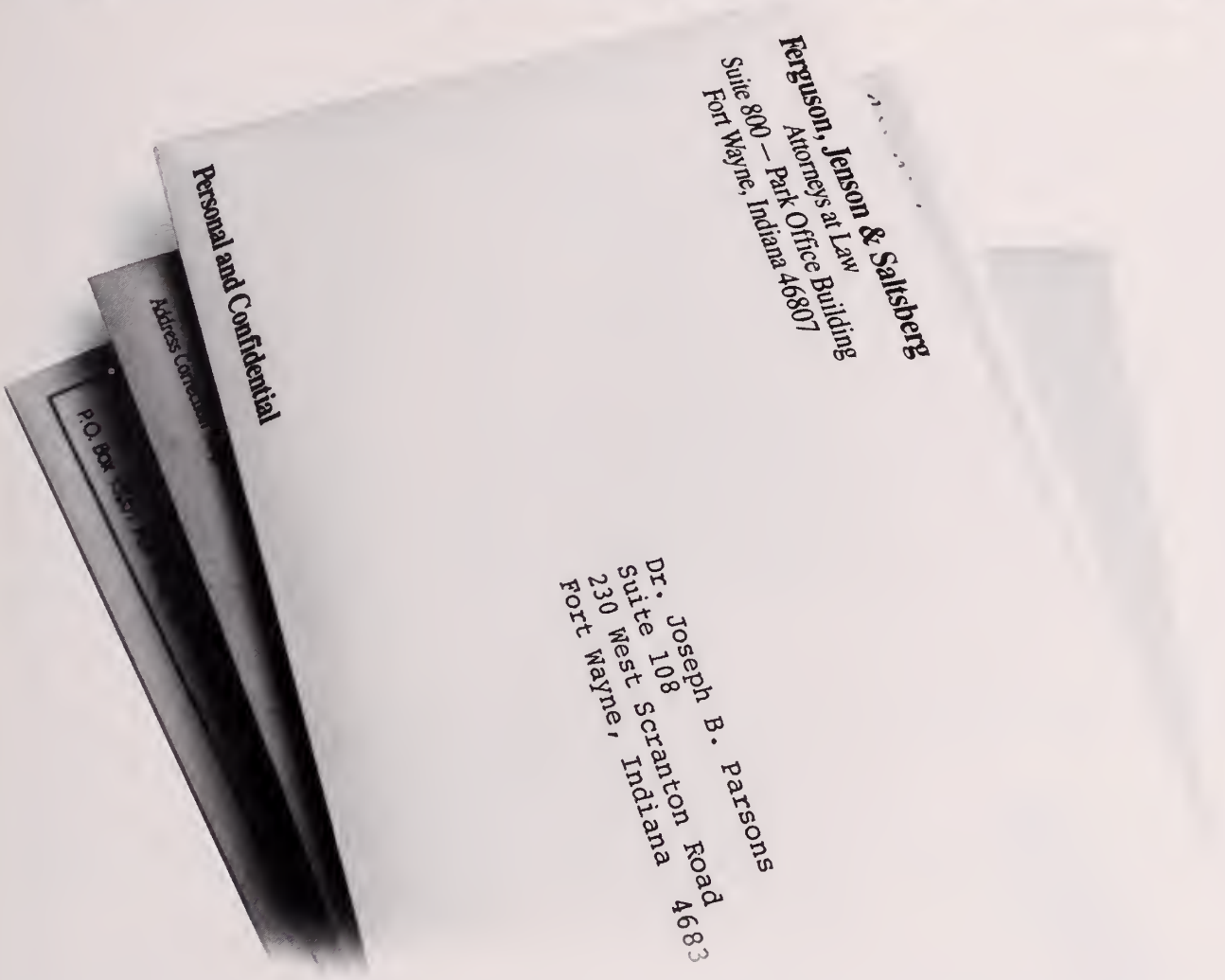

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PIC–Wisconsin now under own management

Physicians Insurance Company (PIC) of Wisconsin has terminated its management services contract with PMC of Wisconsin, Inc., a subsidiary of Physicians Insurance Company of Ohio (PICO).

PIC–Wisconsin was established in 1986 by the SMS with support from PICO to provide medical professional liability insurance to physicians in the state. PMC provided management and administrative services to the company. According to Richard W. Edwards, MD, chairman of the board, PIC–Wisconsin has progressed enough to assume its own management responsibilities. He said the change will not affect the company's policyholders. During its first year of operation, PIC–Wisconsin reported premiums earned of $4.5 million and a net income of $243,329 —or $28.74 per share.■

SMS physician support group rejuvenated

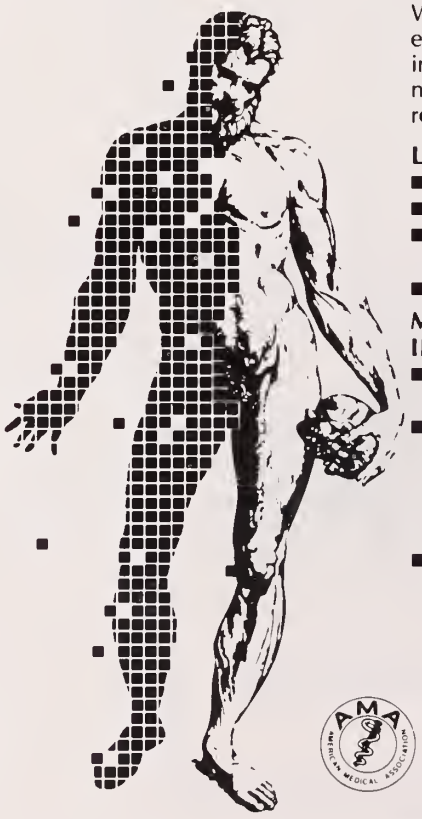
The Physician Support Program, created in 1986 by the SMS Committee on Medical Liability to provide emotional support and advice to physicians who are being sued for malpractice, has been reactivated.

Physicians react to the stress of being sued in a variety of ways including anger, tension, headache and depression, and many handle these reactions by suppressing them while continuing to fulfill their responsibilities to patients and colleagues. The SMS Physician Support Group can help physicians and their families get through this difficult time by providing the following services:

- emotional support;
- helpful information—such as how to work effectively with an attorney;
- an opportunity for physicians and spouses to share their feelings with sympathetic listeners.

A special panel of concerned physicians and spouses, all of whom have been through this experience, can help by providing confidential assistance on an individual basis to any Wisconsin physician or spouse who requests it. For further information, contact Mark Adams in the Division of Medical Policy and Practice at 1-800-362-9080 or 608-257-6781.■

AMA/NET Simplifies the Task of Keeping Up



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Medicare: questions and answers

Q. I read an article in the July/August *Communique* which said the $500 elective surgery provision applies to anesthesiologists. Is this true?

A. The $500 elective surgery provision applies to anesthesiologists only if they perform a surgery over $500. It does not apply to the administration of anesthesia.

Q. Do I need patients to sign each claim form I submit to Medicare?

A. Yes, the patient's signature is required on each claim form unless you obtain authorization from Medicare to keep signatures on file in your office.

To do this, write to the Claims Control Unit at Medicare, and you will receive the agreement. After Medicare accepts your agreement you will need to obtain a one-time payment authorization from these patients or their representatives. This authorization will apply to all current and future treatment you may furnish these patients.

Q. I am a participating physician. Can I bill my patient for a handling charge?

A. A handling charge is a noncovered service under Medicare. Whether you are participating or a nonparticipating physician, you may charge the patient for the handling charge. You do not need to submit this charge to Medicare.

Q. I submitted a claim for an extended office visit (90080). When I received my explanation of Medicare benefits, Medicare had changed the code to a limited office visit (90050). Why?

A. Medicare will allow one extended office visit every six months per patient. This mandated review screen isn't provider specific. Therefore, if the patient has already had an extended office visit billed by another physician, your claim will be downcoded to a limited office visit and approved at this level.

Q. I am a paperless claims submitter. How should I submit claims for services performed by a nonphysician that fall under "incident to" guidelines?

A. When billing Medicare for nonphysician "incident to" services, you must use an NP modifier and box 24c of the HCFA 1500 claim form must indicate the performing provider and the supervising physician. This additional information cannot be submitted on tape, therefore, nonphysician services that fall under the "incident to" guidelines must be submitted on a hard copy claim.

Q. My computer system does not have the capability to print the entire phrase "no purchased diagnostic test" in box 24c of the HCFA 1500 claim form. Will Medicare accept an abbreviation of this phrase?

A. No, Medicare will not accept an abbreviation of this phrase. You must state "no purchased tests are included" in box 24C of each claim form or Medicare will deny the service. If your computer won't print the phrase, use a rubber stamp or write it in.

Q. I'm an anesthesiologist. When I bill for an arterial blood gas in addition to the administration of anesthesia it is denied by Medicare. Why?

A. Under TEFRA law, arterial blood gas performed by an anesthesiologist during the administration of anesthesia is not billable as a sepa-

First annual Ben and Ruth Lawton Lecture
October 6

Frederick C. Robbins, MD, Case Western University School of Medicine Professor Emeritus and co-recipient of the 1954 Nobel Prize in Physiology and Medicine, will deliver the first educational lecture presented in honor of Dr Ben and Ruth Lawton. Robbins' lecture, entitled, "Who will care for the poor—an American dilemma," is scheduled for 8 pm, Thursday, Oct 6, 1988, in the St Joseph's Hospital auditorium, Marshfield. A reception will follow the presentation.

The Ben and Ruth Lawton Lectures, created by the Marshfield Clinic board of directors as a tribute to Dr Ben Lawton and his wife, Ruth, will be held once a year. Reflecting Dr Lawton's interests, the keynote presentations will focus on a medical education or research topic. Lawton was a general and thoracic surgeon at Marshfield Clinic for 33 years, serving as clinic president for seven terms, and was president of the University of Wisconsin board of regents. He was also instrumental in the formation of the Marshfield Medical Research Foundation.

The public is invited.■

rate charge. Therefore, Medicare will not allow this service when billed separately.

Q. I have a spring 1986 HCPCS manual in by office. When will Medicare be updating this manual?

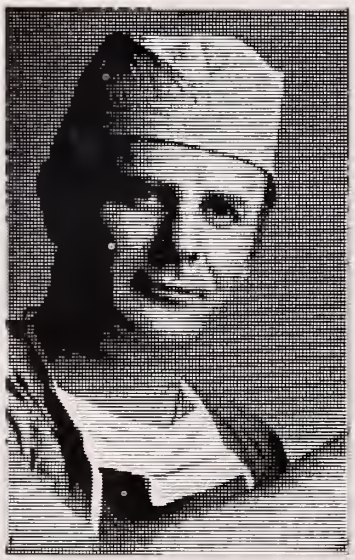
A. The 1988 HCPCS manuals are available by writing to Medicare Customer Service or the Central Provider Control Unit.

Q. Many times I do not receive interest on my claims even though they are over 30 days old. Isn't Medicare supposed to pay interest on claims which take more than 30 days to process?

A. Medicare makes payments on "clean claims" which are not processed in 30 days from the date of receipt. A clean claim is one that does not require investigation or development. Medicare may need to develop on your claim for information which is out of your control. For example, there may be a problem with the health insurance number and Medicare must contact the Social Security Administration. If Medicare needs to contact either the beneficiary or you for additional information, the claim is no longer considered a clean claim. Also, the claim must pass all computerized edits within Medicare's computer system. These edits include patient information (name, address, and health insurance claim number) which must match Medicare's records, the place and type of service must correspond with each other and valid procedure codes must be used. A claim with a not otherwise classified code or a code which requires clarification will automatically suspend in an edit.

If you have questions about Medicare that you would like to see answered in this column, send them to: Medicare Q&A, c/o Karen Lord, State Medical Society of Wisconsin, PO Box 1109, Madison, WI 53701.■

HERE'S ONE DOCTOR WHO WON'T PAY HIS MALPRACTICE PREMIUMS THIS YEAR.



The Army covers that for him. As an Army Physician, there are a lot of worries associated with private practice that he won't have to contend with, such as excessive paperwork, and the overhead costs incurred in running a private practice.

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Physician briefs

*Indicates SMS members.

Walter J. Hogan, MD, of Elm Grove, has been elected president of the American Society for Gastrointestinal Endoscopy. Dr Hogan was graduated from the Medical College of Wisconsin and served a rotating internship at hospitals affiliated with the college. He currently is a professor of medicine at the Medical College of Wisconsin in Milwaukee.

Jan C. Van Schaik, MD,* of Wauwatosa, recently was elected to the board of directors of Transitional Living Services, a nonprofit, community-based treatment facility for emotionally disturbed adults. An assistant clinical professor of psychiatry at the Medical College of Wisconsin, Dr Schaik is president of the Milwaukee Chapter of the Wisconsin Psychiatric Association and a member of the group's task force on patient-therapist sex.

Sidney Shindell, MD, of Milwaukee, recently was named the 1988 recipient of the Sabbatical Support Grant from the Centers for Disease Control. Dr Shindell, who is chairman of preventive medicine at the Medical College of Wisconsin, began his sabbatical at the Caribbean Epidemiology Center of the World Health Organization in Port of Spain, Trinidad. He will shortly move to Thailand, where he will serve with the government in Bangkok; he will return to the US next spring.

Debra Schuster, MD, Suhail Zavaro, MD, and **Charles Strachan, MD,** recently joined the Marshfield Clinic. Dr Schuster, a specialist in cardiac anesthesia, received her medical degree from Washington University of Medicine in St Louis. She served a residency at University Hospital and Clinics in Madison. Dr Strachan recently completed a fellowship in obstetric anesthesia at the University of Pittsburgh and Magee-Women's Hospital. He received his medical degree from the University of Wisconsin Medical School and completed a residency at West Virginia University Hospital in Morgantown. Dr Zavaro received his medical degree from Aleppo University School of Medicine in Aleppo, Syria, and completed a residency in internal medicine at Brown University in Providence, RI.

Curtis W. Bush, MD,* of Beaver Dam, became president of the Wisconsin Academy of Family Physicians at the group's annual meeting in Stevens Point. **Richard G. Roberts, MD,*** of Madison, was chosen president elect.

Clair M. Morud, MD,* and **Dennis L. Zahm, MD,*** both internal medicine specialists, recently joined Medical Associates North in Ashland. A graduate of St Louis University School of Medicine, Dr Morud completed a residency at the University of Nebraska Medical Center in Omaha. Dr Zahm received his medical degree from the Michigan State University College of Human Medicine in East Lansing. He served a residency at McLaren General Hospital in Flint, Mich.

Gerald W. Grim, MD,* recently joined the Marshfield Clinic-Mosinee Center. He received his degree from the University of Minnesota Medical School in Minneapolis and completed a residency in family practice at the Duluth Family Practice Clinic. He previously practiced at the Wausau Medical Center.

Kay B. Sorenson, MD, recently began her practice in Wausau as a pediatrician. She previously was with Child Health Associates in Southfield, Mich.

John R. Sorenson, MD,* recently joined Radiology Associates at Wausau Hospital Center.

Steven J. Pizer, MD,* has joined the Sheboygan Clinic. A graduate of the University of Wisconsin Medical School, Dr Pizer completed a residency in pediatrics at Michigan State University.

Kent D. Braunschweiger, MD, recently joined the General Clinic in West Bend. A graduate of the Loyola-Stritch School of Medicine in Chicago, Dr Braunschweiger served an internship and residency at the Ventura County Medical Center in Ventura, Calif. He previously was

Continued on page 41

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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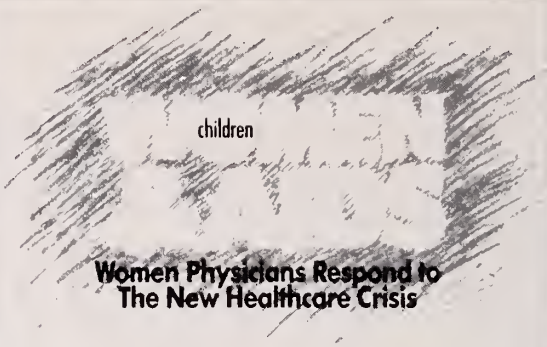

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Tom Ericson, M.D. Steve Herwig, D.O.

Available for interview Washington, D.C. Academy Meeting, Monday, September 26, 1988.

OTO.-HEAD & NECK SURGICAL ASSOC., P.C.
1215 Pleasant Suite 408
Des Moines, Iowa 50309

Continued from page 39

with CIGNA Healthplans of California.

Harry Colt, MD, has joined the staff of Physicians Plus Medical Group in McFarland. A graduate of Case Western Reserve University School of Medicine, Dr Colt is a family practice specialist. He completed a residency at the University of Virginia Medical Center.

Scott H. Warren, MD,* has joined the medical staff at Memorial Medical Center in Ashland. An orthopedic surgeon, Dr Warren received his degree from the Medical College of Wisconsin and served an internship and residency at the Akron General Medical Center in Akron, Ohio.

Max Smith, MD,* of Madison, recently retired after 35 years of practice. A psychiatrist, Dr Smith was instrumental in establishing the state's first community hospital psychiatric unit at St Mary's from 1969 to 1972, served on the hospital's board of advisors for six years and was chairman of the psychiatry section for six years. Dr Smith was a founder and president of the Wisconsin Psychiatric Association and was an assistant professor at the University of Wisconsin Medical School. He received his medical degree from UW in 1944.

James Conterato, MD, Ade Dillon, MD, and **Bardomiano Sanchez, MD**, recently joined the Marshfield Clinic. An anesthesiologist, Dr Conterato served an internship and residency in Marshfield and was on the Marshfield Clinic's staff from 1983 to 1985 in the Department of Internal Medicine. He recently completed an anesthesia residency at the Mayo Clinic in Rochester, Minn. He received his degree from Rush Medical College in Chicago. Dr Dillon received his medical degree from the West Virginia University School of Medicine in Morgantown. He completed an internship and residency in Marshfield and returns to the clinic as a physiatrist. Dr Sanchez received his degree from the Brown University Program in Medicine in Providence, RI. He completed a residency in internal medicine at Brown University and the Miriam Hospital.

B. Tucker Woodson, MD, David P. Dielentheis, MD,* and **John T. Livermore, MD,*** all recently joined the Sheboygan Clinic. Dr Woodson graduated from the University of Missouri–Columbia and completed a general surgery internship and a residency in otolaryngology at the Henry Ford Hospital in Detroit. Dr Dielentheis, a specialist in obstetrics and gynecology, received his degree from the University of Minnesota Medical School. He completed his internship and residency at St Joseph's Hospital In Milwaukee. An orthopedic surgeon, Dr Livermore was graduated from the University of Wisconsin Medical School. He completed an internship and residency at the State University of New York Upstate Center in Syracuse.

John J. Bussa, MD,* Patrick Sitorius, MD, and **Ronald Boran-Ragotzy, MD,*** all have joined Janesville Medical Ltd. Dr Bussa graduated from the University of Texas Health Science Center in San Antonio, Texas, and served an internship at Brooke Army Medical Center, also in San Antonio. He served a residency in ophthalmology at Walter Reed Army Medical Center in Washington, DC. A family practice specialist, Dr Sitorious received his medical degree from the University of Nebraska-Omaha, where he also served an internship and residency. He previously was with the Cozad Medical Clinic in Cozad, Neb. Dr Boran-Ragotzy received his medical degree from Wayne State University in Detroit. He served a residency and internship at SMAHEC in Kalamazoo, Mich. He is a fellow of the American Academy of Allergy and Immunology.

Narasimhulu Neelagaru, MD,* of Neillsville, recently was awarded a fellowship in the American College of Physicians. Dr Neelagaru, who is associated with Neillsville Clinic, SC, was previously awarded fellowships in the American College of Cardiology and the American College of Chest Physicians.

Rodney D. Wichmann, MD,* has retired after 34 years as a family physician in the Wild Rose area. He graduated from the University of Wisconsin Medical School in 1952.

Richard A. Hoversten, MD, recently joined the staff of Doctors Clinic Ltd and Two Rivers Family Medicine. He received his medical degree at the University of Iowa.

Norman A. Hoeffleur, DO,* of West Allis, was recently named General Practitioner of the Year at the Mid-America Osteopathic Medical Convention and Scientific Assembly in Milwaukee. He was graduated from the Chicago College of Osteopathic Medicine.■

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Specialty society news

The Wisconsin Academy of Family Physicians installed Curtis W. Bush, MD, Beaver Dam, as its 41st president during the WAFP Annual Meeting held at Stevens Point in June. Dr Bush succeeds Dr David E. Westgard of La Crosse.

Richard G. Roberts, MD, Madison, was elected president-elect and will take office as president at the 1989 Annual Meeting.

Arne T. Lagus, MD, St Croix Falls, was elected secretary-treasurer.

D. Mark Lochner, MD, Waupaca, was newly elected to the board of directors for a three-year term; Jerri Britsch, MD, Milwaukee, was elected to a one-year term on the board, and representing the residents in training, H. Schumacher, a student at the University of Wisconsin Medical School, Madison, was elected as the student representative. Re-elected to the board for three-year terms were Drs Ann R. Berlage, Platteville, and Christopher J. Zellmer, Milwaukee.

Terry Hankey, MD, Waupaca, was elected speaker of the WAFP Congress of Delegates, and Alan D. Strobusch, MD, New London, was elected vice-speaker.

Charles L. Steidinger, MD, Platteville, was re-elected to a two-year term as a delegate to the AAFP, and Jack Strong, MD, Mauston, was re-elected as his alternate. Dr Westgard was elected a one-year term at alternate delegate.

Lloyd P. Maasch, MD, Weyauwega, was chosen as 1988 Family Physician of the Year, and Marc F. Hansen, MD, Madison, was named 1988 Family Practice Educator of the Year. Dr Hansen teaches family medicine to residents and students at the University of Wisconsin.

The WAFP Congress of Delegates passed a resolution encouraging academy members to promote sex education in their practices and in their communities, to set up special programs for adolescents for the purpose of providing sex education on an individual basis and in group settings, and to work with local hospitals and schools and other community organizations to make medically sound sex education available to as many adolescents as possible. The resolution was prompted by family physicians' concerns about the health and well-being of the adolescent patients in their practices, especially in regard to developing responsible attitudes about sexuality, prevention of unwanted pregnancies and prevention of sexually transmitted disease.■

AMA Awards

The Wisconsin Physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers its congratulations. The * indicates members of the SMS.

JUNE 1988

*Barash, Harvey L., Madison
*Bixby, Mark R., Grantsburg
*Bond, Jeffrey R., West Allis
Borden, Ernest C., Madison
*Davila, Julio C., Wausau
*Finkel, Michael F., Eau Claire
*Gonzalez, Celerina N., Glendale
*Haase, Sharon L., Beaver Dam
Heckman, Margaret G., Wood
*Holtey, Warren J., Marshfield
*Kelley, William B., Milwaukee
*Kim, Byung H., Racine
*Kropp, August D., Milwaukee
*Matzke, Robert F., Janesville
McConnell, Mark E., La Crosse
*Mohammad-Zadeh, Ali A., Green Bay
*Pfefferkorn, Ethan D., Colby
Pierce-Ruhland, Richard A., Racine
*Poley, Carl R., Green Bay
*Praxel, Theodore A., Wisconsin Rapids
Reganti, Venkata R., Neillsville
*Shapiro, Robert B., Madison
*Siegel, Lawrence K., Waukesha
*Sneed, Robert J., Ashland
*Sovine, David L., Glendale
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*Williams, David R., Kenosha
Wright, William E., Mondovi
*Zondlo, Joseph G., Green Bay■

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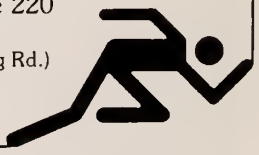

Physicians Exchange

Minnesota, Iowa, and Wisconsin group practice positions are available for BE/BC physicians in the following specialties: Family Practice, Adult/Child Psychiatry, Internal Medicine, Occupational Medicine, Pediatrics, and Obstetrics/Gynecology. Competitive salary with benefits. Send letter of inquiry and curriculum vitae to Scott M. Lindblom, Fairview Clinic Services, 2312 South 6th St, Minneapolis, MN 55454 or call 612-371-6235 or toll-free 1-800-328-4661, ext 6235. An equal opportunity employer. p8–9/88

Five-member Cardiology Group seeking BE/BC associate with invasive/noninvasive capabilities. Medical referral center for northeastern and east central Wisconsin. Liberal guarantee/benefit arrangements. Full partnership available. Send CV or call: Dr James Cole, Appleton Cardiology Associates SC, 820 East Grant St, Appleton, WI 54911; 414-731-8900. p8–10/88

Anesthesiology, Dermatology, Family Medicine, General Surgery, Internal Medicine, Orthopedics, Otolaryngology, OB/GYN, Pediatrics, Psychiatry. ALRMG is a 37-MD non-HMO clinic in beautiful Albert Lea, Minn. These positions are created by retirements and development of new departments. The hospital and clinic are modern, progressive, established and the primary health care providers in our service area. Excellent educational and cultural opportunities. Competitive income, excellent benefits, early shareholder status with first year salary guarantee with incentive options. Send CV to Administrator, ALRMG, 1602 Fountain St, Albert Lea, MN 56007-1642 or call 507-373-8251 for further information. p8–10/88

RATES: 50¢ per word, with a minimum charge of $20.00 per ad. BOXED AD RATES: $25.00 per column inch. *All ads must be prepaid.*

DEADLINE: Copy must be received by the 1st of the month preceding month of issue; *eg,* copy for the August issue is due July 1. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free in Wisconsin: 1-800-362-9080.

Green Bay. Seeking full-time and part-time physicians for busy emergency department. Outstanding compensation and full malpractice insurance coverage. Benefit package available to full-time staff. Contact: Emergency Consultants, Inc, 2240 S. Airport Road, Room 36, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496. p9/88

Immediate opening, BC/BE Internist, competitive salary guaranteed with incentive formula. Midwest. Available now or July 1989. Send CV and inquiries to Dept 622 in care of the *Journal.* p9/88

Psychiatrist/Chemical Dependency Psychiatrist interested in chemical dependency needed to join 220-physician multispecialty group with adjacent 447-bed hospital. Position includes inpatient services for Chemical Dependency Unit with full range of outpatient chemical dependency services available; Evaluation and Detoxification Unit; outpatient chemical dependency clientele and follow-up; general psychiatric practice also available. Behavioral Medicine Department is presently staffed by seven psychiatrists, one child/adolescent psychiatrist and two psychologists. New clinic building recently completed. Gundersen Clinic, Ltd, is located in La Crosse, Wisconsin, a progressive community of 50,000 built along the shores of the Mississippi River amid scenic bluffs, the city offers excellent recreational facilities. Numerous educational and cultural opportunities are provided by an expanding university with undergraduate and graduate degree programs, and a private liberal arts college. Excellent pension program, no investment required. Service organization: Write: Philip J. Dahlberg, MD, Chairman, Personnel Committee, Gundersen Clinic, Ltd, 1836 South Ave, La Crosse, WI 54601. An Equal Opportunity Employer. 9/88

Family Practice—Madison, Wisconsin. Eleven-year-old staff model HMO has a family practice position available. We offer a very attractive practice setting with reasonable scheduling, excellent salary, and benefits. Contact John Hansen, MD, Medical Director, Group Health Cooperative, One South Park, Madison, WI 53715; ph (608) 257-9700. 7–9/88

Physicians needed full- or part-time to perform light physicals. Milwaukee area. Professional liability provided. Phone 414/344-2100, Ms Jenkins. 10tfn/84

Otolaryngologist. South Central Illinois. Less than 100 miles to St Louis, and 70 miles to Terre Haute, Ind. Association with three BC ENTs seeking to establish second office in community with 50,000 service population, or establish an independent, fee-for-service practice. Excellent income potential. Call or write George Ivekich, 250 Regency Court, Waukesha, WI 53186; 1-800-338-7107 or 414-785-6500 (collect for Wisconsin residents). 9/88

Family Practice. Two physician clinics in west suburban Minneapolis seeks a third BC/BE family practitioner to join a busy growing practice. OB optional. Competitive first year salary with partnership opportunity. Contact: Daniel J. McCormick, Medical Resource Group, France Place, Suite 920, 3601 Minnesota Dr, Bloomington, MN 55435; ph 612-835-5123. 9/88

Family Practice. Three physician family practice in Duluth seeks BC/BE family practitioner to replace retiring senior physician. Competitive guaranteed salary and benefits and partnership opportunity. Contact Daniel J. McCormick, Medical Resource Group, France Place, Suite 920, Minnesota Drive, Bloomington, MN 55435; ph 612-835-5123. 9/88

Due to retirement, we are seeking a third general surgeon for the surgical department of a 55-member multispecialty clinic in Janesville, Wisconsin. The clinic is on the grounds of a modern and well-equipped hospital with three outlying primary care satellites in neighboring communities. Janesville, Wisconsin, is a city of 51,000 people centrally located between Madison and Milwaukee, Wisconsin, and Chicago, Illinois. Vascular experience is necessary. Excellent benefits are provided. Salary for the first year and then full partnership. If interested, send curriculum vitae to Ronald P. Karzel, MD, Janesville Riverview Clinic, 580 N Washington St, Janesville, WI 53545. 8–10/88

Kewaunee, Wisconsin. Family practice as it was intended to be. Unique opportunity for two family practioners to join a strong practice. Good working relationship with well-staffed local hospital. Excellent specialty support with on-premise consultation. If the intrinsic values of medicine are important to you, look at this opportunity. Salary guaranteed with future partnership available. Travel and expenses for interview paid for qualified applicants. For more information, call Tom Zenner, MD; ph: 414-388-4640 collect. 9/88

General Internist. Marshfield Clinic, a 260-physician multispecialty group practice, is seeking BE/BC general internal medicine specialists to join its expanding department in Marshfield, Wisconsin. The department is currently staffed by 23 general internists with immediate plans to add seven or more additional members. The current call schedule is generally one night per month and one out of five weekends. An Internal Medicine Residency Program, University of Wisconsin Medical School Affiliation, Medical Research Foundation, and ongoing new developments, ie, Geriatrics Evaluation Center and Walk-In Medicine contribute to a very stimulating environment. Our community of 20,000 offers strong economic stability combined with exceptional recreational, cultural, and educational opportunities. We offer a current starting salary up to $85,000 with salary in two years up to $110,000. Fringe benefit package outstanding. Send CV and references to: David L. Draves, Department of Administration, 1000 North Oak Ave, Marshfield, WI 54449 or call collect 715-387-5376. 9/88

Family Practitioner. Excellent opportunity to associate with a successful group practice. Young, five-member group is seeking a Board-certified or eligible family practitioner to replace one member leaving the area. Salary guarantee, ownership opportunity in one year. Clinic is adjacent to 40-bed JCAH accredited hospital. Community located in scenic four season recreation area within easy driving of large population centers. Send CV and references to Michael Nelli, Manager, Cumberland Clinic, PO Box 127, Cumberland, WI 54829. p8–9/88

West Bend, Wisconsin, General Clinic, a 20-physician multispecialty group is seeking additional B/C, B/E physicians in **Family Practice, Pediatrics, OB/GYN, Internal Medicine, Urology, Dermatology,** and **ENT.** First-year salary and benefits guaranteed. Corporate association after one year. Located in a family-oriented, economically strong small city surrounded by four-season recreational and scenic Kettle Moraine area 30 miles north of metropolitan Milwaukee. Contact Hans W. Schmelzling, Administrator, 279 S 17th Ave, West Bend, WI 53095; ph 414/338-1123. 7tfn/87

Emergency Medicine, Otolaryngologist, Urologist, and Obstetrician/Gynecologist to join multispecialty group practice in Woodruff, WI. Guaranteed annual income and excellent fringe benefit program. Send CV to R.J. Sloan, MD, Lakeland Medical Associates, Ltd, PO Box 549, Woodruff, WI 54568. 4tfn/88

The Wausau Medical Center is seeking BC/BE individuals in the following specialties: Cardiology, Dermatology, Family Practice, Infectious Disease, Obstetrics/Gynecology, Pediatrics and Rheumatology. Modern clinic facility located across the street from modern 300-bed hospital. Full partnership in three years. Easy access to lakes, woods and mountains. Write including CV to D.K. Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, WI 54401. p4tfn/88

Family practice. Thirty-four physician multispecialty group conveniently located between Chicago and Milwaukee. Well-equipped clinic offering salary guarantee with incentive bonus; excellent fringe benefits and early ownership. Please send current curriculum vitae to Roger D. Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 4tfn/88

General Surgeon and **Family Practice** opportunities in a group setting. Located in a family-oriented economically strong small city. Located near lakes and metro area of Green Bay and Appleton, Wis. Send CV to Andrew Lagatta, President, Clintonville Community Hospital, 35 N Anne St, Clintonville, WI 54929. 6–10/88

Rheumatologist—the Racine Medical Clinic, a 34-physician multispecialty group conveniently located between Chicago and Milwaukee. Well equipped clinic offering salary guarantee with incentive bonus; excellent fringe benefits and early ownership. Please send curriculum vitae to: R.D. Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 11tfn/87

Career opportunity for qualified Emergency Room physician. Our group covers two hospital emergency rooms and an active walk-in clinic in southeastern Wisconsin. Full fringe benefit package and flexible scheduling offered. Interested parties contact John W. Linstroth, MD, 1201 Sherwood Lane, Caledonia, WI 53108; ph 414-835-7761. 8tfn/88

NEW PHYSICIANS FOR WISCONSIN
is seeking
• Family Physicians • Pediatricians
• Orthopedic Surgeons • Internists
Contact: Fred Moskol
UW Office of Rural Health
810 University Bay Drive
Madison, WI 53705
608/263-7933
7–12/88;1–6/89

BC/BE General Internist to join 26-MD multispecialty group with four internists, one nephrologist and one gastroenterologist. Top salary first year, full incentive thereafter. Central Wisconsin university town with drawing area of 80,000. Send CV to Dr John Gauder, Rice Clinic, SC, 2501 Main St, Stevens Point, WI 54481, or call collect 715/344-4120. 12tfn/87

Twenty-nine physician multispecialty clinic located in desirable East Central Wisconsin location is seeking Board-certified or Board-qualified orthopedic surgeon to round out its services. Lab, x-ray, excellent hospital. Liberal guarantee and benefits. If interested contact D.F. Sweet, MD, Fond du Lac Clinic, SC, 80 Sheboygan St, Fond du Lac, WI 54935. 9tfn/87

Invasive Cardiologist. Monroe Clinic near Madison, 54-physician group seeks third cardiologist. 270-bed hospital, new cath lab, attractive salary, benefits. Contact Dept 620 in care of the Journal. p8–10/88

Internal Medicine. Doctors Clinic, Two Rivers, Wisconsin. Eight-physician group seeks second internist, critical care interest beneficial, three area hospitals. Contact Dept 621 in care of the Journal. p8–10/88

General and Vascular Surgeon, university trained, sought as ambitious associate for very busy surgeon. Rewarding, hard work in sophisticated medical community. Robert Mikkelsen, MD, FACS, 14 N Main St, Fond du Lac, WI 54935. p8;9–11tfn/88

Family Practice (BC/BE) opportunity to join a five-physician family practice group in south central Wisconsin city of 15,000. Pleasant community atmosphere within 1–1½ hours of Madison and Milwaukee. Excellent recreational area. First year guaranteed salary. Contact: Chad Burchardt, Business Manager, Medical Associates of Beaver Dam, SC, 1200 N Center St, Beaver Dam, WI 53916; ph: (414) 887-7101. p9–11/88

Miscellaneous

For Sale. Adult exam tables, pediatric exam tables with scales, x-ray machine 60 MA (Universal), x-ray machine 30 MA portable (Fischer), ICP copier, Saxon copier, office chairs, refrigerator, Unimeter, Dynaclave sterilizer, various medical instruments. Call 414-463-0080, 9:00–5:00. 9/88

Wanted to purchase: Established pediatric practice in Milwaukee. Days: (414) 771-0500; evenings: (414) 781-1497. 7–9/88

Physicians Exchange

continued

Medical Consulting Opportunities. The Bureau of Social Security Disability occasionally has openings for part-time consultants who provide medical evaluation on disability claims. Twenty to thirty-five hours per week on hourly compensation. No fringe benefits. Flexible schedule and an East/Central Madison office location. Current opening is for a neurologist. Interested physicians in other fields may submit resumes for consideration of other openings in the future. Contact Dr Fred W. Fletcher, BSSDI, PO Box 7886, Madison, WI 53707-7886; ph 608-266-6608. 9–10/88

Family Practitioner to join a progressive 12-physician practice at its Ellsworth, Wisconsin branch. Rural community 40 miles from St Paul, Minn. Liberal benefit package. Salary commensurate with background and experience. Contact R.M. Hammer, MD, River Falls, WI 54022; ph (715) 425-6701 or (612) 436-8809. 7tfn/88

Internal Medicine. Board-certified or eligible to join five general internists in a multispecialty group in northeastern Wisconsin. Office is next to two hospitals. Partnership is available after one year. Send CV to Dept 613 in care of the Journal. p4–9/88

RURAL WISCONSIN HOSPITAL COOPERATIVE

Emergency Room Physicians

The Rural Wisconsin Hospital Cooperative (RWHC) is a nationally recognized and award winning organization that provides advocacy and shared services for its 20 member hospitals. We are seeking ACLS certified physicians with Family Practice, Internal Medicine or ER backgrounds and strong communication skills to provide coverage for our participating hospitals. The hospitals served by RWHC are within a two-hour drive from Madison, Wisconsin. Many have ACLS trained nursing staffs and modern emergency room facilities. This network offers flexibility in scheduling, with needs ranging from part to full-time coverage. A competitive salary and access to a variety of benefit options is available.

Contact: Patricia Ruff, Associate Director, RWHC, 404 Phillips Blvd, Sauk City, WI 53583; 608-643-2343. 9/88

Family Practice. Marshfield Clinic is seeking BE/BC Family Practitioners to join its expanding department in Marshfield. The department is currently staffed by five family practitioners with plans to add three additional members. With the exception of obstetrics, which is done by staff obstetricians, the practice offers a full range of inpatient and outpatient services. Full specialty consultation is readily available in-house. Our community of 20,000 offers strong economic stability combined with exceptional recreational, cultural, and educational opportunities. We offer a current starting salary up to $85,000 with salary in two years up to $110,000. Fringe benefit package outstanding. Send CV and references to David L. Draves, Department of Administration, 1000 North Oak Ave, Marshfield, WI 54449 or call collect 715-387-5376. 9/88

Orthopedic Surgeon Board-certified/eligible to join a 24-physician multispecialty group in Winona, Minnesota. Total patient population draw area of 40,000. Interested physicians please contact: Jerome B. Knuesel, Administrator, Winona Clinic, Ltd, 420 East Sarnia, Winona, MN 55987. 8–10/88

General Internist/Endocrinologist, Cardiologist / Rheumatologist, BE, Board-certified to join a 16-man internal medicine department in a dynamic growing multispecialty clinic. Attractive salary with a full range of benefits. Mid-size midwestern community with excellent educational, recreational, social activities. Please send CVs and references to: Ross A. Madden, MD, Medical Director, Medical Associates Clinic, PC, 1000 Langworthy, Dubuque, IA 52001. 8–10/88

ORTHOPEDIC SURGEON
NEUROSURGEON
PHYSIATRIST
Industrial Rehabilitation

Outpatient orthopedic clinic seeking additional physicians to join growing industrial rehabilitation center specializing in disability evaluation, treatment, medical management, functional capacity assessment, work-hardening programming and employer consultation services. Part-time and full-time opportunities. Excellent guaranteed salary with incentives plus excellent fringe benefits. Please send CV to:

Bone & Joint Surgery Associates
Chiron Rehabilitation Clinic
2704 Marshall Court
Madison, Wisconsin 53705
(608) 231-3030
7–9/88

Family Practitioner. Family Practice physician wanted to be associated with branch clinic of a large multispecialty group. Opportunity for family practice in Prairie du Chien, Whitehall, Viroqua or Tomah, Wisconsin; West Union, Iowa. Physician would be associated with a multispecialty group. Relief provided for vacations, meetings, etc. Educational opportunities through an excellent education program. Beautiful countryside, cultural, and recreational facilities. Excellent fringe benefits. Salary commensurate with background and experience. Write or call: Tim Skinner, MSEd, Family Practice Representative, Gundersen Clinic, Ltd, 1836 South Ave, La Crosse, WI 54601. Equal Opportunity Employer. 9/88

Internists/Family Practitioners. Banner Elk, North Carolina. Four-season resort area. Solo practice opportunities available. OB optional. Seventy-nine bed JCAH accredited hospital adjacent to professional building. Salary guaranteed first year. Professional building rent free first year. Contact Administrator, Cannon Memorial Hospital, POB 8, Banner Elk, NC 28604; ph 1-704-898-5111. p9/88

Family Practice/Internal Medicine. Attractive opportunities for Board-certified/board-eligible family practice and internal medicine physicians in Wisconsin and Michigan. Contact Bob Strzelczyk to discuss these positions and your practice requirements. Strelcheck & Associates, Inc, 12724 N. Maplecrest Lane, Mequon, WI 53092; 414-243-9500 (collect). Outside Wis 800-243-4353. p9/88

Internist with or without subspecialty interests. Board-certified or eligible to join a well-established nine man expanding multispecialty group. Location is in a southeastern Wisconsin city of 36,000 with access to a large inland lake, initial salary plus percentage as an associate. Full status in-service corporation with shared overhead and an incentive orientated formula after the first year. Please contact E.T. Ayala, MD, Department of Internal Medicine, Sharpe Clinic, SC, 92 East Division St, Fond du Lac, WI 54935; ph (414) 921-0560, collect. p6–11/88

Eagle River—Great opportunity for two BC/BE family practice physicians to join well-established practice. Guaranteed annual income and future partnership available. For more information, send resume to Judy Harris, Recruiter, UW Office of Rural Health, 810 University Bay Dr, Madison, WI 53705 or call collect 608/263-7933. 1tfn/88

Physicians Exchange

continued

Wisconsin. OB/GYN (BC/BE) needed to join dynamic HMO-based multispecialty group practice. University town of 55,000 near Minneapolis. Community and recreation outstanding. Competitive salary and fringes. We take pride in our patient care. Contact Robert A. Braastad, MD, Group Health Cooperative, 1030 Regis Court, Eau Claire, WI 54701; ph 715-836-8552. p5/88;6-9/88

Real Estate

For Rent. Doctor's Office, Hales Corners, Wisconsin, area 1050 sq ft. New building, first floor, ample parking. Reception, business office, three plumbed examining rooms, laboratory, private office and bath. For information call 414-764-6692 or 414-744-8007. 8tfn/88

Medical Meetings—Continuing Medical Education

SEPTEMBER 8–10, 1988: Wisconsin Academy of Physician Assistants Fall CME meeting, "Health Care Approaching the '90s," at Red Carpet Hotel, Milwaukee. g9/88

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, clinics, specialty societies, and medical schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 50¢ per word, with a minimum charge of $20.00 per listing. *All listings must be prepaid.*

BOXED LISTINGS: $25.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 1st of the month preceding the month of publication; *eg,* copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free in Wisconsin: 1-800-362-9080.

SEPTEMBER 22–23, 1988: Wisconsin Clinic Managers Association, Devil's Health Resort, Baraboo. g9/88

OCTOBER 1, 1988: *Wisconsin Society of Radiation Oncologists,* Concourse Hotel, Madison. 4tfn/88

OCTOBER 8, 1988: Wisconsin Neurological Society, Landmark Resort, Egg Harbor. g9/88

OCTOBER 14–15, 1988: Wisconsin Neurosurgical Society, Marshfield Clinic/St Josephs Hospital, Marshfield. g9/88

OCTOBER 20–21, 1988: Wisconsin Chapter, American College of Emergency Physicians, The Abbey, Lake Geneva. 2tfn/88

OCTOBER 28–30, 1988: Wisconsin Psychiatric Association, Landmark Resort, Egg Harbor. g9–10/88

NOVEMBER 4, 1988: *Wisconsin Orthopaedic Society,* Olympia Resort, Oconomowoc. 4tfn/88

SAVING THE MYOCARDIUM
Present-Day Management of Acute Myocardial Infarction

1988 American Heart Association of Wisconsin Annual Meeting
Friday, October 21, 1988
Country Inn, Pewaukee, Wis

Scientific Sessions:
8:00 am–12:00 pm
Annual Meeting and Business Session: 12:30–2:30 pm

Special presentations by top experts on:
THROMBOLYTIC THERAPY
PERCUTANEOUS CORONARY ANGIOPLASTY
EARLY PHARMACOLOGIC TREATMENT
POST-THROMBOLYSIS FOLLOW-UP

Keynote Speaker: A. James Liedtke, MD, Professor of Medicine, Cardiology Section, University of Wisconsin Hospital, Madison, Wisconsin.

CEU and CME credits

To register, or for additional information contact: The American Heart Association of Wisconsin, 795 North Van Buren St, Milwaukee, WI 53202; ph 414-271-9999 or 800-242-9236. p9/88

NOVEMBER 5, 1988: Wisconsin Allergy Society, InnTowner Hotel, Madison. Info: Robert Bush, MD, 2500 Overlook Terr, Madison, WI 53705; ph (608) 256-1909. gtfn/88

DECEMBER 7–9, 1988: Neurology for the Non-Neurologist, The Ambassador West Hotel, Chicago, Ill. Info: Office of Continuing Medical Education, Rush-Presbyterian-St. Luke's Medical Center, 600 S. Paulina, Chicago, IL 60612; ph 312-942-7095. 9–10/88

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CONTINUING MEDICAL EDUCATION

Sponsored by Marshfield Clinic
Marshfield, Wisconsin

JANUARY 25–27, 1989:
Cancer 89, Telemark Lodge, Cable

FEBRUARY 4, 1989: *Science Teachers Conference,* Marshfield

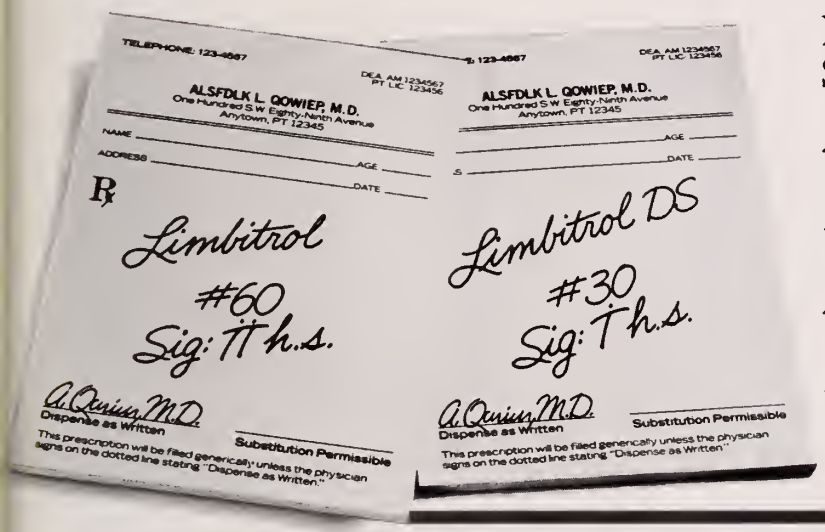
FEBRUARY 9–10, 1989:
Winter Pediatric Conference, Big Powderhorn Ski Resort, Bessmer, Michigan

MARCH 10–11, 1989:
Advanced Cardiac Life Support Course, Marshfield

Further information or a brochure call the Marshfield Clinic's Office of Medical Education, 1000 North Oak Ave, Marshfield, WI 54449; ph 715-387-5207. 9-12/88

In moderate depression and anxiety

- 74% of patients experienced improved sleep after the first *h.s.* dose[1]
- First-week improvement in somatic symptoms[1]
- 50% greater improvement with Limbitrol in the first week than with amitriptyline alone[2]



Protect Your Prescribing Decision: Specify "Do not substitute."

Limbitrol®

Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) Ⓒ IV

Limbitrol® DS

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) Ⓒ IV

References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner VP, *et al: Psychopharmacology 61*:217-225, Mar 22, 1979.

Limbitrol®Ⓒ
Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.**

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. *Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. *Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. *Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. *Endocrine:* Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

How Supplied: *Double strength (DS) Tablets,* white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets,* blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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Manati, Puerto Rico 00701

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In the depressed and anxious patient

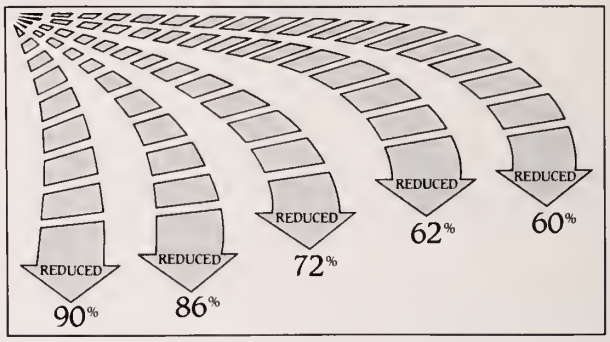
See Improvement In The First Week...[1]

And The Weeks That Follow

- 74% of patients experienced improved sleep after the first *h.s.* dose[1]
- First-week reduction in somatic symptoms[1]

Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

Percentage of Reduction in Individual Somatic Symptoms During First Week of Limbitrol Therapy*



*Patients often presented with more than one somatic symptom.

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V. 87, NO. 10

Wisconsin Medical Journal

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October 1988

Wisconsin Medical Journal

The *Wisconsin Medical Journal* (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor and editor are responsible for overseeing the production, business operation and contents of the journal. The editorial board, chaired by the medical editor, solicits and screens all scientific, special and soundings articles. The editorial director provides leadership for the editorial associates and comments on both editorials and letters to the editor. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *WMJ* nor the SMS take responsibility. The *WMJ* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

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State Medical Society of Wisconsin

Created by the Territorial Legislature in 1841 and now representing nearly 7,000 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal*.

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Our cover: "Radiology," an oil painting by Aaron Bohrod. The original is part of the collection of the SMS Charitable, Educational and Scientific Foundation and hangs in the Fort Crawford Medical Museum, Prairie du Chien.

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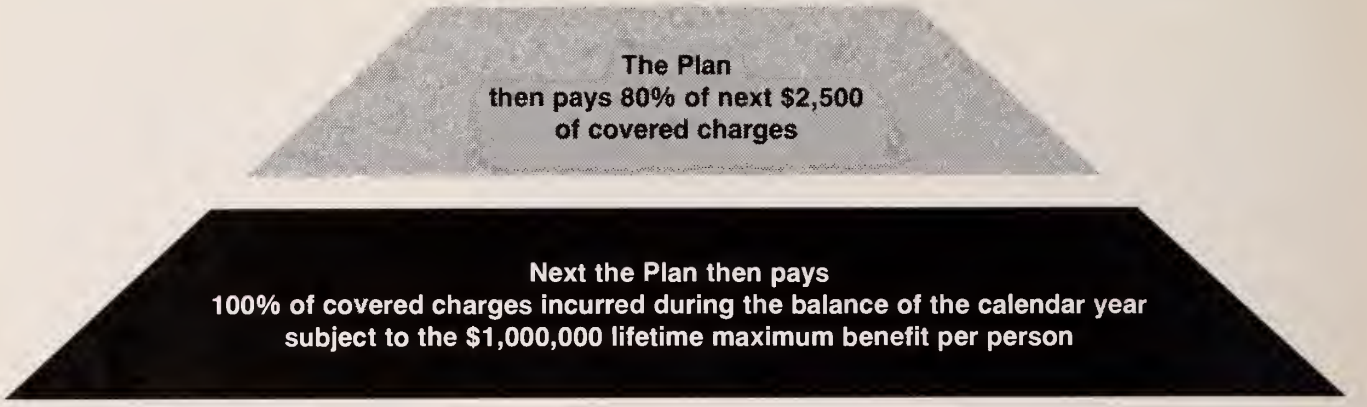

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President's page

Learning to speak the language

FALL HAS ARRIVED and the air is full of footballs, flying leaves and politics. Next month we will choose a new Wisconsin legislature with which we will need to come to new understandings in the ensuing months. Mutual understanding is vital because when Wisconsin physicians and Wisconsin legislators misunderstand each other, poor public policy, unworkable laws, needless restrictions, unproductive requirements, higher costs and bad feelings follow. Ideally, each group should serve as a trusted advisor to the other, but this ideal can go unrealized if the participants have different goals, values and language. Not worse goals, values and language, just different.

Although physicians and legislators differ, there are salient similarities which can enhance communication. The average age of both groups is 45 years. Fifteen percent of physicians and 20% of legislators are women. Both groups have above average education, work long hours, respond to (patients', constituents') problems, enjoy heir work, supervise employees, worry about the future, become tired and irritable, and see too little of their families. Both vocations cope with innumerable and irreconciable demands from many groups and individuals with conflicting interests and preferences. Only a few in each group are lazy or rude, and only a very few in each group are scoundrels whose conduct defames their colleagues.

During a legislative session, more than 2,000 bills and resolutions are introduced, ranging from minor to major and trivial to profound. Major health related bills of concern to patients and their physicians likely to come before the new legislature include professional liability reform, AIDS and HIV infection policies, mandatory assignment, rural health, reform of involuntary commitment standards, and a "natural death" law. Each bill will be argued and amended, and accepted or rejected.

The data upon which a decision (vote) must be based will come from public hearings, letters (by the thousands), communications from trade, union and professional (special interest) groups and their representatives (lobbyists). Seldom will these sources entirely agree. Ultimately the lawmaker is obliged to make a decision based upon data sufficient for action but insufficient to satisfy the intellect. The result is always a compromise which is inevitably unsatifactory to some. Too many "wrong" votes and too many dissatisfied voters mean the legislator will not survive the next election (lose his or her "license") and be unemployed.

Legislative proposals affecting health, illness and medical practice are particularly difficult for legislators. Health issues tend to be complex and to involve large numbers of people, large amounts of money and fervent opinions. Physicians' organizations which do not agree among each other provide incoherent (to the lawmakers) guidance. Amid this clamor of conflicting opinion, the

JD Kabler, MD

SMS must represent our proposals persuasively to convince legislators that our views are valid and should prevail. Overcoming suspicions that the SMS is just another special interest trade association can be a challenge. What we regard as quality of care concerns are construed by some as only economically driven turf battles.

Legislators think, feel, experience and talk applied political science. Physicians think, feel, experience and talk applied medical science. Neither group is familiar or comfortable with the content and jargon of the other's species of science. Both groups use the concepts and idioms of their own science in communicating with the

other and consequently each understands the other imperfectly. If we physicians want our viewpoints to prevail, it is up to us to translate these views into a pragmatic political science language, comprehensible to a lawmaker. As with any second language, it must be learned and practiced. The special language and values of pragmatic politics are the topics of next month's SMS seminars in Oconomowoc and Stevens Point, during which techniques for effectively communicating with lawmakers will be emphasized. (For more information on registration, call the SMS Division of Public Affairs at 1-800-362-9080, toll free.)

Informed participation in the political process does matter. It is not a dirty job best left to others. We dare not respond to "what is worse, ignorance or apathy?" with "I don't know and I don't care."■

A call for photographs

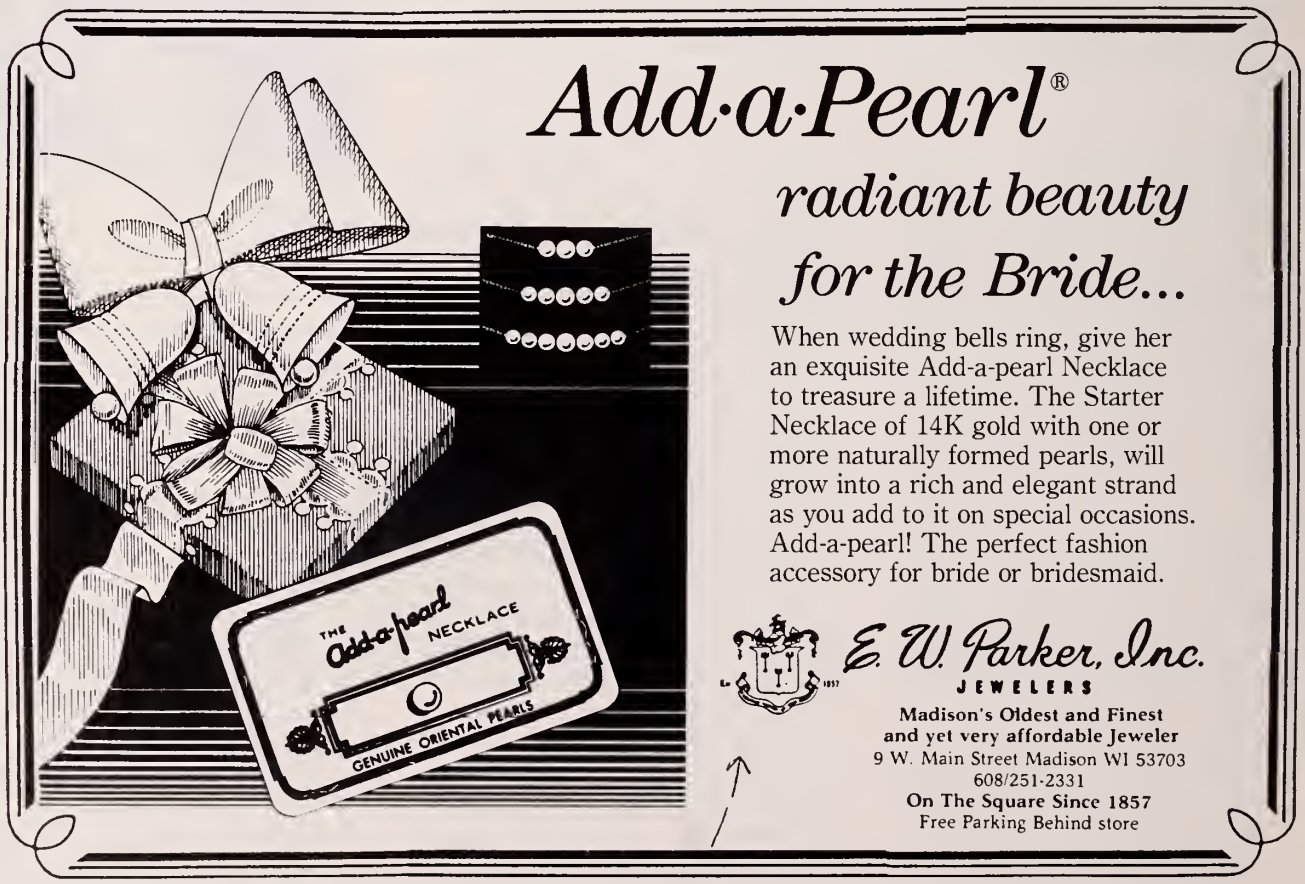
The *Wisconsin Medical Journal* and the SMS Charitable, Educational, and Scientific Foundation are joining forces in an effort to build a photographic library of medicine in Wisconsin. Donations of current or historical photos relating to medicine—persons or places, equipment or events—are welcome and tax deductible. All donated photos will become the property of the Fort Crawford Medical Museum, which is owned and operated by the foundation, and may be used to illustrate future issues of the *Wisconsin Medical Journal.* Send your photos to: Thomas L. Adams, State Medical Society of Wisconsin, PO Box 1109, Madison, WI 53701-1109.■

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

Editorials are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of editorials is reserved for members of the *WMJ* editorial board, editorial associates and SMS elected officers.

Letters are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of letters is open to the public, but letters are limited to 500 words and subject to review by the *WMJ* editorial board.■



Secretary's report

Making room for the future

THE BOARD OF DIRECTORS of the Society began yet another new chapter in the history of the Society in awarding contracts totaling $1.8 million to expand, renovate and refurbish the SMS headquarters at 330 E Lakeside St in Madison. The project had been previously authorized by the House of Delegates on recommendation of the Board.

During its long history, the State Medical Society has occupied offices in several locations before moving to its existing home on Lakeside.

The main headquarters building was completed in 1955, and was constructed in an attempt to consolidate Wisconsin Physicians Service and the State Medical Society under a single roof, but even after the building was constructed some segments of SMS and WPS were housed elsewhere in the city.

The west wing of SMS headquarters, which now houses the Visiting Nurse Service and Physicians Insurance Company of Wisconsin (PIC-W), was completed in 1962 in response to the need for additional office space. In 1986, due to staff expansion, the SMS Division of Communications occupied the basement level of the west wing. The portions of this wing occupied by PIC-W and SMS were renovated last year.

As part of the SMS campus, a service building was constructed in the mid-1960s, which now houses our print shop, mail room facilities and storage.

Over the years, the Society has purchased other properties in the general vicinity of the headquarters as they have become available at fair market prices. Most of those parcels are rented to tenants and produce non-dues revenue for the Society.

In developing plans for renovating the facility, we projected space needs for the next five to seven years for SMS, SMS Services, the CES-Foundation, and PIC-W. By the end of that term, PIC-W will likely outgrow the space available for expansion in the west wing of the building. With continued growth of SMS Services, the Foundation and SMS staff, we project a need to occupy the space leased by PIC-W at approximately the same time that the company will outgrow that space. At that time, the Society will need to consider if it wishes to develop other properties to house the company.

Thomas L. Adams

The buildings on SMS grounds have been well maintained since their initial construction. Other than minimal remodeling to add or delete office space and secretarial areas, little has been done to modernize the buildings. In most areas of the building, old furnishings, floor coverings, and wall coverings remain. Perhaps

An artist's rendition of the remodeled SMS headquarters.

more importantly, all of the heating, ventilating and air conditioning systems, as well as the electrical and plumbing, are pretty much original equipment.

For these reasons, the Board of Directors, as approved by the House of Delegates, instructed the SMS staff to hire an architect, develop plans and receive bids for the project. Subsequently, the Madison architectural firm of Potter, Lawson and Pawlowsky was selected to design the project. Mike Gordon served as lead architect and Tim Smirl as the interior designer. Arnold & O'Sheridan was chosen by the architects as the engineers for the project. A separate consultant, Dames & Moore was selected to draw specifications for asbestos removal.

J. H. Findorff & Son, Inc. has been awarded the general contract for the addition and renovation. Interestingly, this same contractor built the west wing addition in 1962.

Highlights of the renovation include a new front entrance for the building, an addition in the board room area and enlarged restrooms on the first floor. Small telephone rooms have been added for the convenience of members attending meetings in the facility.

As our committees, commissions, and task forces have become more active, competition for meeting space has become intense, especially on Fridays. The addition to the board room will allow four simultaneous committee meetings to occur in the building, thereby eliminating a need to schedule those meetings out of the building at considerable expense.

During the construction period from now until next July, all committee meetings will be held at the Sheraton on John Nolen Drive. The staff will be relocated, from December to July, to the current VNS space in the west wing.

While the renovation will undoubtedly cause some inconvenience for both members and staff, we will have a first-rate facility upon completion of the project—one which should serve us well as we enter the 21st century.

Medicina Nusquam Non Est!■

Editorial

The physician's role in fighting child abuse

I WAS DISCUSSING a child abuse trial with one of our county social workers a few months ago. The case itself was unremarkable, as abuse cases go. The child had a congenital limb deformity which investigators felt may have made him the object of his parents' antipathy. The inflicted lesions were indisputable—loop marks (from being beaten with a wire coat hanger), bruises corresponding to finger marks, a couple of healed lesions which appeared to be cigarette burns, and older bruises of nondescript shape over the child's back. The case was presented and judgment rendered in under 90 minutes. The child went into foster care. Pretty much run-of-the-mill—except for one thing: The social worker mentioned the physician's willingness to testify and the impact his testimony and presence made at the trial.

"It is so rare," she said.

"Rare that a physician's testimony makes a difference?" I asked.

She looked at me. "No," she said. "I meant that it is rare to get a physician to testify willingly."

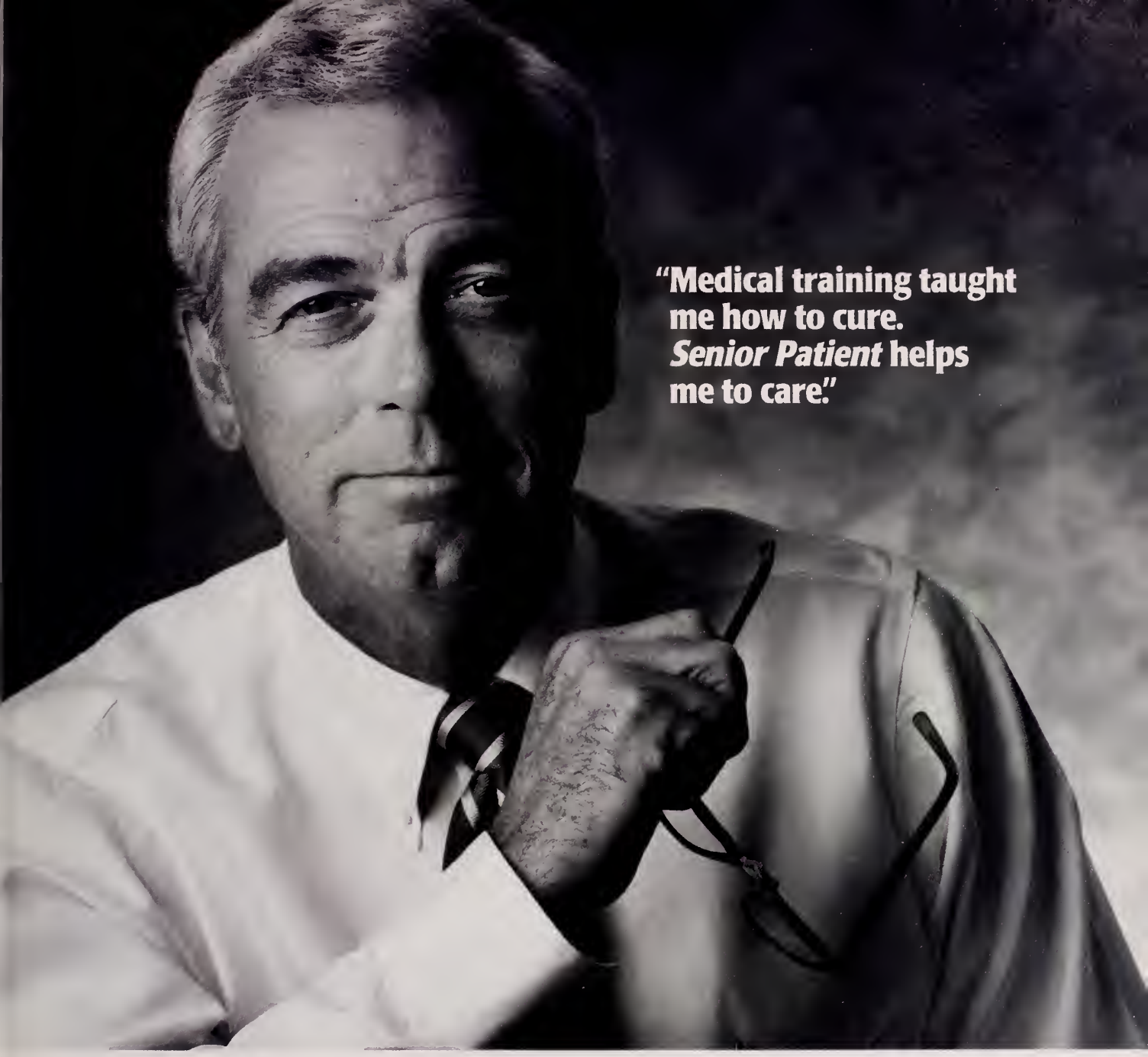
She went on to explain. Many physicians, for various reasons, are reluctant to appear at abuse hearings. Some are reluctant to face an aggressive defense attorney who is attempting to do a slash-and-burn on the prosecution's charges. Many are reluctant to lose time from the office because a physician called to testify in an abuse case is usually entitled only to a flat subpoena compensation, and not to a far more substantial expert witness fee.

The social worker remarked on the efforts made by her department to involve physicians personally in abuse hearings only when absolutely necessary. To minimize the inconvenience to physicians, chart records alone are used as much as possible, and the physician is subpoenaed only in exceptional cases. The social worker acknowledged that this is not an ideal situation, and that she wished that physician participation in abuse hearings was easier to come by.

On the surface of it, there would appear to be little incentive for a physician to appear in court willingly. It would seem that no one in their right mind would relish the prospect of giving up an afternoon's income to have their professional skill and integrity publicly savaged by a representative of Rottweiler, Doberman, and Schweinhundt, SC, Counselors-at-Law.

These disincentives are, however, beside the point. A physician is not asked to appear in court for reasons of personal or financial enhancement. A physician who testifies in a child abuse hearing does so for humanitarian reasons, pure and simple. In the short term, children cost everybody—parents, local government, the state, and the nation—money. This cost is justified as an investment in the future of the family and society. Physicians are serving their communities and defenseless children when they testify

Continued on page 8



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Continued from page 6

on a child's behalf in abuse hearings. Moreover, the physician's ability to serve in this regard is, for a couple of reasons, unique.

First, a physician's notes and conclusions, combined with lab data, x-rays, and photographs, constitute a formidable weapon in the prosecution of a child abuse case—when wielded by the physician in person. To a medically unsophisticated social worker, physicians' notes may become vague and obscure, full of imprecise references, unfamiliar technical terms, and other medical jargon. The significance of abnormal (or normal) laboratory findings, x-rays, or photographs may be understated or totally missed. The physician's weapon becomes the social worker's mine field, and the social worker's unfamiliarity with medicine may in fact become a weapon in the hands of the defense attorney. It is unfortunate, but perhaps predictable, that the physicians who who write the most ambiguous notes are also the physicians who are most reluctant to appear in court.

Second, in addition to this unique ability to clarify and amplify the written record, the physician, merely by his or her presence, lends tremendous weight to the prosecution's case. The physician in court makes a statement far exceeding that of the most exhaustive and analytical chart record. The chart simply says, "These are the findings." The physician's presence says, "I care. I want to make sure, for this child's sake, that others understand what I found and know what my conclusions are."

There is no substitute for the personal appearance. Think of the number of times you made a point of being present at a particular event. It could have been a hospital staff meeting, your wedding anniversary, parents' night at your child's summer camp, or a discussion of the (lack of) yardwork done by your son. Whatever it was, you knew your presence was somehow vital, and you acted accordingly. So it is with a child abuse hearing.

It is not just a matter of saying, "Nobody does it better." Nobody else can do it—period.

The time and money lost through a few hours spent in court are hardly significant when considered in light of the good a physician can do on behalf of a child, society, and the profession by testifying in an abuse hearing. The call to testify comes only very occasionally for most of us, and the influence we can have in a court hearing is inestimable. No abused child could hope to have a better friend in court than a competent, sympathetic physician—and no abused child should have to do without one.

—Jeffrey H. Lamont, MD
Wausau■

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Bone and Joint Infections caused by *Enterobacter cloacae, Serratia marcescens,* and *Pseudomonas aeruginosa*

Urinary Tract Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Serratia marcescens, Proteus mirabilis, Providencia rettgeri, Morganella morganii, Citrobacter diversus, Citrobacter freundii, Pseudomonas aeruginosa, Staphylococcus epidermidis,* and *Streptococcus faecalis.*

Infectious Diarrhea caused by *Escherichia coli* (enterotoxigenic strains), *Campylobacter jejuni, Shigella flexneri,** and *Shigella sonnei** when antibacterial therapy is indicated.

*Efficacy for this organism in this organ system was studied in fewer than 10 infections.

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A history of hypersensitivity to ciprofloxacin is a contraindication to its use. A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin.

WARNINGS

CIPROFLOXACIN SHOULD NOT BE USED IN CHILDREN OR PREGNANT WOMEN. The oral administration of ciprofloxacin caused lameness in immature dogs. Histopathological examination of the weight-bearing joints of these dogs revealed permanent lesions of the cartilage. Related drugs such as nalidixic acid, cinoxacin, and norfloxacin also produced erosions of cartilage of weight-bearing joints and other signs of arthropathy in immature animals of various species (SEE ANIMAL PHARMACOLOGY SECTION IN FULL PRESCRIBING INFORMATION).

PRECAUTIONS

General

As with other quinolones, ciprofloxacin may cause central nervous system (CNS) stimulation, which may lead to tremor, restlessness, lightheadedness, confusion, and very rarely to hallucinations or convulsive seizures. Therefore, ciprofloxacin should be used with caution in patients with known or suspected CNS disorders, such as severe cerebral arteriosclerosis or epilepsy, or other factors which predispose to seizures (SEE ADVERSE REACTIONS).

Crystals of ciprofloxacin have been observed rarely in the urine of human subjects but more frequently in the urine of laboratory animals. Crystalluria related to ciprofloxacin has been reported only rarely in man, because human urine is usually acidic. Patients receiving ciprofloxacin should be well hydrated, and alkalinity of the urine should be avoided. The recommended daily dose should not be exceeded. Alteration of the dosage regimen is necessary for patients with impairment of renal function (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

Drug Interactions

Concurrent administration of ciprofloxacin with theophylline may lead to elevated plasma concentrations of theophylline and prolongation of its elimination half-life. This may result in increased risk of theophylline-related adverse reactions. If concomitant use cannot be avoided, plasma levels of theophylline should be monitored and dosage adjustments made as appropriate.

Antacids containing magnesium hydroxide or aluminum hydroxide may interfere with the absorption of ciprofloxacin, resulting in serum and urine levels lower than desired; concurrent administration of these agents with ciprofloxacin should be avoided.

Probenecid interferes with the renal tubular secretion of ciprofloxacin and produces an increase in the level of ciprofloxacin in the serum. This should be considered if patients are receiving both drugs concomitantly.

As with other broad-spectrum antibiotics, prolonged use of ciprofloxacin may result in overgrowth of nonsusceptible organisms. Repeated evaluation of the patient's condition and microbial susceptibility testing is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Information for Patients:

Patients should be advised that ciprofloxacin may be taken with or without meals. The preferred time of dosing is two hours after a meal. Patients should also be advised to drink fluids liberally and not take antacids containing magnesium or aluminum concomitantly or within two hours after dosing. Ciprofloxacin may cause dizziness or lightheadedness; therefore patients should know how they react to this drug before they operate an automobile or machinery or engage in activities requiring mental alertness or coordination.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Eight *in vitro* mutagenicity tests have been conducted with ciprofloxacin and the test results are listed below:

- Salmonella/Microsome Test (Negative)
- *E. coli* DNA Repair Assay (Negative)
- Mouse Lymphoma Cell Forward Mutation Assay (Positive)
- Chinese Hamster V_{79} Cell HGPRT Test (Negative)
- Syrian Hamster Embryo Cell Transformation Assay (Negative)
- *Saccharomyces cerevisiae* Point Mutation Assay (Negative)
- *Saccharomyces cerevisiae* Mitotic Crossover and Gene Conversion Assay (Negative)
- Rat Hepatocyte DNA Repair Assay (Positive)

Thus, two of the eight tests were positive, but the following three *in vivo* test systems gave negative results:

- Rat Hepatocyte DNA Repair Assay
- Micronucleus Test (Mice)
- Dominant Lethal Test (Mice)

Long-term carcinogenicity studies in animals have not yet been completed.

Pregnancy – Pregnancy Category C:

Reproduction studies have been performed in rats and mice at doses up to six times the usual daily human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ciprofloxacin. In rabbits, as with most antimicrobial agents, ciprofloxacin (30 and 100 mg/kg orally) produced gastrointestinal disturbances resulting in maternal weight loss and an increased incidence of abortion. No teratogenicity was observed at either dose. After intravenous administration, at doses up to 20 mg/kg, no maternal toxicity was produced, and no embryotoxicity or teratogenicity was observed. There are, however, no adequate and well-controlled studies in pregnant women. SINCE CIPROFLOXACIN, LIKE OTHER DRUGS IN ITS CLASS, CAUSES ARTHROPATHY IN IMMATURE ANIMALS, IT SHOULD NOT BE USED IN PREGNANT WOMEN (SEE WARNINGS).

Nursing Mothers

It is not known whether ciprofloxacin is excreted in human milk, however, it is known that ciprofloxacin is excreted in the milk of lactating rats and that other drugs of this class are excreted in human milk. Because of this and because of the potential for serious adverse reactions from ciprofloxacin in nursing infants, a decision should be made to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use

Ciprofloxacin should not be used in children because it causes arthropathy in immature animals (SEE WARNINGS).

ADVERSE REACTIONS

Ciprofloxacin is generally well tolerated. During clinical investigation, 2,799 patients received 2,868 courses of the drug. Adverse events that were considered likely to be drug related occurred in 7.3% of courses, possibly related in 9.2%, and remotely related in 3.0%. Ciprofloxacin was discontinued because of an adverse event in 3.5% of courses, primarily involving the gastrointestinal system (1.5%), skin (0.6%), and central nervous system (0.4%).

The most frequently reported events, drug related or not, were nausea (5.2%), diarrhea (2.3%), vomiting (2.0%), abdominal pain/discomfort (1.7%), headache (1.2%), restlessness (1.1%), and rash (1.1%).

Additional events that occurred in less than 1% of ciprofloxacin courses are listed below. Those typical of quinolones are italicized.

GASTROINTESTINAL: *(See above),* painful oral mucosa, oral candidiasis, dysphagia, intestinal perforation, gastrointestinal bleeding

CENTRAL NERVOUS SYSTEM: *(See above), dizziness, lightheadedness, insomnia, nightmares, hallucinations, manic reaction, irritability, tremor, ataxia, convulsive seizures, lethargy, drowsiness, weakness, malaise, anorexia, phobia, depersonalization, depression, paresthesia*

SKIN/HYPERSENSITIVITY: *(See above), pruritus, urticaria, photosensitivity, flushing, fever, chills, angioedema, edema of the face, neck, lips, conjunctivae or hands,* cutaneous candidiasis, hyperpigmentation, erythema nodosum

SPECIAL SENSES: *blurred vision, disturbed vision, (change in color perception, overbrightness of lights), decreased visual acuity, diplopia, eye pain, tinnitus, bad taste*

MUSCULOSKELETAL: *joint or back pain, joint stiffness,* achiness, neck or chest pain, flare-up of gout

RENAL/UROGENITAL: *interstitial nephritis, renal failure,* polyuria, urinary retention, urethral bleeding, vaginitis, acidosis

CARDIOVASCULAR: palpitations, atrial flutter, ventricular ectopy, syncope, hypertension, angina pectoris, myocardial infarction, cardiopulmonary arrest, cerebral thrombosis

RESPIRATORY: epistaxis, laryngeal or pulmonary edema, hiccough, hemoptysis, dyspnea, bronchospasm, pulmonary embolism.

Most of these events were described as only mild or moderate in severity, abated soon after the drug was discontinued, and required no treatment.

In several instances, nausea, vomiting, tremor, restlessness, agitation, or palpitations were judged by investigators to be related to elevated plasma levels of theophylline possibly as a result of a drug interaction with ciprofloxacin.

Adverse Laboratory Changes: Changes in laboratory parameters listed as adverse events without regard to drug relationship:

Hepatic – Elevations of: ALT (SGPT) (1.9%), AST (SGOT) (1.7%), alkaline phosphatase (0.8%), LDH (0.4%), serum bilirubin (0.3%)

Hematologic – eosinophilia (0.6%), leukopenia (0.4%), decreased blood platelets (0.1%), elevated blood platelets (0.1%), pancytopenia (0.1%).

Renal – Elevations of: Serum creatinine (1.1%), BUN (0.9%).

CRYSTALLURIA, CYLINDRURIA, AND HEMATURIA HAVE BEEN REPORTED.

Other changes occurring in less than 0.1% of courses were: Elevation of serum gammaglutamyl transferase, elevation of serum amylase, reduction in blood glucose, elevated uric acid, decrease in hemoglobin, anemia, bleeding diathesis, increase in blood monocytes, and leukocytosis.

OVERDOSAGE

Information on overdosage in humans is not available. In the event of acute overdosage, the stomach should be emptied by inducing vomiting or by gastric lavage. The patient should be carefully observed and given supportive treatment. Adequate hydration must be maintained. In the event of serious toxic reactions from overdosage, hemodialysis or peritoneal dialysis may aid in the removal of ciprofloxacin from the body, particularly if renal function is compromised.

DOSAGE AND ADMINISTRATION

The usual adult dosage for patients with urinary tract infections is 250 mg every 12 hours. For patients with complicated infections caused by organisms not highly susceptible, 500 mg may be administered every 12 hours.

Respiratory tract infections, skin and skin structure infections, and bone and joint infections may be treated with 500 mg every 12 hours. For more severe or complicated infections, a dosage of 750 mg may be given every 12 hours.

The recommended dosage for infectious diarrhea is 500 mg every 12 hours.

In patients with renal impairment, some modification of dosage is recommended (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

HOW SUPPLIED

Cipro® (ciprofloxacin HCl/Miles) is available as tablets of 250 mg, 500 mg, and 750 mg in bottles of 50, and in Unit-Dose packages of 100 (SEE FULL PRESCRIBING INFORMATION FOR COMPLETE INFORMATION).

*** Due to susceptible strains of indicated pathogens. See indicated organisms in Brief Summary.**

CONVENIENT *B.I.D.* DOSAGE

Recommended dosage schedule

Infection Site*	Severity of Infection	Dosage
Respiratory Tract*	Mild/Moderate	500 mg *B.I.D.*
Bone and Joint*		
Skin/Skin Structure*	Severe/Complicated	750 mg *B.I.D.*
Urinary Tract*	Mild/Moderate	250 mg *B.I.D.*
	Severe/Complicated	500 mg *B.I.D.*
Infectious Diarrhea*	Mild/Moderate/Severe	500 mg *B.I.D.*

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Clinical cancer: 28

Gastric cancer

ALTHOUGH THE INCIDENCE of gastric malignancy has steadily decreased in our country for the last five decades, it is not an uncommon disease in Wisconsin. Gastric cancer is nearly as prevalent as leukemia or pancreatic cancer.[1]

General considerations

A definitive plan for the prevention of stomach cancer has yet to be developed. It is clear, however, that some dietary considerations are in order. Obesity is one avoidable risk factor. The habitual ingestion of salt-cured, smoked, pickled, or nitrate-cured foods seems to account for the higher incidence of this malignancy in certain national populations. A low incidence of gastric cancer is found in peoples who frequently consume fruits and vegetables. There is no evidence of specific occupational hazards, but there seems to be an inverse relationship to socioeconomic status. The lack of household refrigeration in developing countries also appears to be an important factor. Surprisingly, the use or abuse of alcohol and tobacco are not significant for gastric cancer formation although these agents are acknowledged to be formidable inciters of esophageal malignancy.

Management of stomach cancer

The current management of stomach cancer patients may be improved in two ways: early detection followed by prompt treatment and the selection of appropriate palliative modalities for the incurable.

Early diagnosis. Screening of asymptomatic patients by radiological or endoscopic techniques, or both, has been practiced in Japan with some success because of the high prevalence of this malignancy in that country. Such efforts in the United States, if performed at all, are confined to the few persons at high risk. Deserving of such consideration might be the achlorohydric patients, whether their condition results from atrophic gastritis or pernicious anemia, and the members of a family showing a clustering of gastric cancer cases. A more recently detected risk group are patients who 20 years ago or more underwent a subtotal gastrectomy or gastroenterostomy for benign disease. All patients with a previous biopsy showing gastric mucosal metaplasia, as well as individuals with unresectable or recurrent gastric adenomtous polyps, deserve frequent imaging and endoscopy to detect an early gastric adenocarcinoma.

The symptomatic patient usually has only a vague indigestion or early satiety and perhaps an insidious weight loss. As many as 10% of gastric cancer patients have symptoms identical to those with classic peptic ulcer disease. Only the advanced cancer patient shows the classic symptoms of meat intolerance and cachexia and an epigastric mass.

Worldwide, the disease is found more often in men at a ratio of 3:2, but this is of little consequence for the individual patient in the clinical setting. Achlorhydria is usually not found in early gastric cancer, so that the absence of acid is an ominous prognostic sign. Because there are no telltale signs, symptoms, or physical findings in the curable person, a high index of suspicion on the part of the diagnostician remains the classic admonition. Occult blood in the stool is more likely to be detected if performed on multiple occasions, but, alas, the guaiac test may be consistently negative in early malignancy.

An upper gastrointestinal roentgenogram series can detect the fungating

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and deeply infiltrating adenocarcinomas with considerable reliability, and an endoscopic biopsy may confirm the radiologic impression. Those lesions that manifest as superficial infiltration or as shallow ulceration are much more difficult to diagnose radiologically. A four- to six-week therapeutic trial of intensive medical treatment to heal ulcers that failed to show radiographic evidence of malignancy had been the standard management prior to the widespread availability of experienced endoscopists. This delay may now be avoided by obtaining representative endoscopic biopsies from the ulceration "up front." A month or six weeks of medical management should not only heal these ulcers, but prevent recurrence as well. Careful follow-up is needed to detect the perverse masquerading of a few early malignant lesions.

All gastric cancer patients should undergo surgical exploration unless their condition is preterminal or beyond. Only the presence of malignant ascites, distant proven metastases, extensive liver replacement by tumor, or a rectal shelf should contraindicate exploration. Emergent surgical intervention is required when a gastric neoplasm is accompanied by viscus perforation or massive hemorrhage; otherwise, preoperative evaluation and preparation may proceed with due deliberation. Even in the presence of obstruction, continuous nasogastric tube decompression of the stomach will permit a timely thoroughness. Total parenteral alimentation is of assistance when malnutrition might otherwise preclude surgery. Computerized tomography is useful for the detection of lymph node enlargement, perigastric extension, and liver involvement. Preoperative preparation using nonabsorbable antibiotics has been proven to reduce the infectious complications of resection.[2]

Surgical approaches. Surgical extirpation is the only effective treatment for cure. Resection is performed for regionally localized cancer and should encompass all actual and potential lymphatic extensions. In the United States, the operative procedure is dictated by the site and extent of gastric involvement. For distal stomach lesions, the splenic hilum nodes are rarely involved, so that the spleen may be spared. Otherwise, the resected subtotal gastrectomy specimen includes the greater omentum, a generous portion of the lesser omentum, the spleen, and lymph nodes from the vascular pedicles dissected en bloc. Whether a distal or proximal subtotal gastrectomy is performed, frozen sections of both lumenal ends of transection will help to insure tumor-free suture lines.

For more extensive stomach involvement, a total gastrectomy may be performed without fear of subsequent malnutrition. It is a paradox that a large bulky cancer may exhibit limited extension and thereby be amenable to curative gastrectomy. When possible, the preservation of a small serosal-bearing gastric cuff will add to the safety of the jejunal anastomosis. More controversial is the value of routine retroperitoneal node clearance and distal pancreatectomy, although this radical approach is favored in Japan. For involvement by direct extension or by lymph node metastasis to adjacent organs such as the pancreas, transverse colon, or liver, resection en bloc with the gastrectomy should lead to a reasonable prognosis.

The cure rate for adenocarcinoma of the stomach has not dramatically increased in recent years. The overall five-year survival time in the United States does not exceed 12%, whereas in Japan it is 50% for resected patients. This reflects the Japanese emphasis on early detection and perhaps a penchant for extended total gastrectomy.

Other treatments. Palliation is best achieved by gastrectomy (subtotal or total).[3] Removing the involved segment of the stomach can bring remarkable relief, while the possible complications of perforation, obstruction, and hemorrhage are virtually nonexistent. Additional debulking, when feasible, has apparent value, especially if chemotherapy is to be used postoperatively.

All too often, only a gastrojejunostomy is performed when the exploration discloses that the patient is incurable. This bypass procedure will only temporarily relieve obstructive symptoms, while entirely failing to alleviate the patient's fetid breath, anorexia and abdominal discomfort.

Radiation treatment for the cure of gastric adenocarcinoma has been unsuccessful. The most radioresistant cells of the normal stomach mucosa are the mucus-producing cells from which the gastric adenocarcinoma is usually derived. The doses required to eradicate bulky stomach adenocarcinomas are also beyond the tolerance of the surrounding normal tissues. Preoperative, intraoperative and postoperative radiotherapy have each been used alone or in combination with little benefit, mainly in Japan. Radiation is useful for the palliation of pain especially that from focal osseous metastasis. It is also useful for unresectable local or residual disease and for unresectable recurrent cancer. There is mounting evidence that x-ray therapy combined with chemotherapy produces a greater therapeutic effect.

A universally effective chemotherapeutic agent or combination of agents for stomach adenocarcinoma has yet to be discovered. Some drugs have proven cancerocidal activity, but none demonstrates total cancer cell kill in the clinical setting. Thus chemotherapy is not a treatment for cure.

5-fluorouracil (5-FU) has been used extensively as a single agent, and the degree of palliation achieved in responders has been good. When 5-FU is used in combined drug regimens, the addition of doxorubicin has been effective in increasing the response rate. The best choice for a

third agent has yet to be decided; to mention a few, methyl-CCNU, mitomycin-C, or most recently, cisplatin, have each been given clinical trials. It is hoped that the incidence of response as well as the duration of palliation can be improved by a combination drug schedule. For patients receiving chemotherapy in the adjunctive setting, an increased survival time has not been achieved.

Other gastric cancers. Malignant lymphoma and leiomyosarcoma occur less frequently, accounting for only 4% and 1% of gastric cancer patients. The stomach lymphoma is usually of the non-Hodgkin's type and may occasionally be confined to that organ. The clinical setting presents an excellent opportunity for cure by radical gastrectomy. At the time of this operation, a biopsy of the liver plus paraaortic and iliac lymph node sampling will provide the staging information essential for proper treatment. Although this tumor is radiosensitive, radiation therapy is not used because of the danger of perforation. In selected cases, radiotherapy has proven to be of value when given postoperatively, whereas chemotherapy is employed for the more generalized disease.

The benign leiomyoma is more common than its sarcomatous counterpart. Wide surgical excision of the sarcoma is once again the treatment of choice.

Adenocarcinoma of the esophagus

This disease is predominant in men by a seven-to-one margin.[4] Usually involving the lower esophagus, this cancer was believed to always represent a primary gastric cardia tumor that grew upward into the esophagus. Recent pathophysiologic study has disclosed, however, that acid, pepsin, or bile regurgitation into the esophagus may result in chronic esophagitis with progression to a columnar cell replacement of the normal squamous cell epithelium. This transformation known as Barrett's esophagus is now recognized to be a premalignant lesion for the subsequent development of a primary adenocarcinoma.

Endoscopic survey and biopsy of patients with Barrett's esophagus should lead to the detection of early cases. Currently these cancers are most often found only after they become symptomatic and are therefore moderately advanced lesions. This cancer may extend proximally along the esophageal submucosal plane, invade the diaphragm or pericardium by direct extension, and can metastasize more remotely to the liver. As is true for gastric adenocarcinoma, the presence of a large bulky tumor mass need not preclude resection of the lesion.

The anatomic position of this malignancy presents the surgeon with maximum difficulty. Radical proximal gastrectomy en bloc with distal esophagectomy, employing both an abdominal and thoracic approach, permits a mediastinal dissection with restoration of gastroesophageal continuity within the thorax. This operation can often provide a cure, but carries a high risk of morbidity and mortality. Another variant of this operation is the interposition of colonic or jejunal segments to reestablish digestive tract continuity.

Resection via the abdomen using a transhiatal esophagectomy in continuity with proximal gastrectomy and reconstruction by cervical esophagogastrostomy is a better tolerated procedure resulting in excellent palliation.[5] Esophageal adenocarcinomas confined to the esophagus or with metastases only to the immediately adjacent lymph nodes can be cured by this operation. The reporting of larger series of bluntly dissected esophageal resections will ultimately provide a basis for a statistically valid comparison of these two operations or at least a better definition of the surgical candidates appropriate to each procedure.

The effectiveness of radiotherapy and chemotherapy for adenocarcinomas of the esophagus appears to parallel the results of that for gastric adenocarcinoma, although the literature is relatively scant.

Summary

The incidence of gastric adenocarcinoma continues to decline worldwide but still remains an all too common clinical problem.

The most curable lesions are frequently nearly asymptomatic. Surgical resection remains the only cure as well as the best palliative treatment for this disease. Patients who respond to chemotherapy, radiotherapy, or to a combination of both, can experience significant palliation of symptoms, but there appears to be no overall improvement in longevity for all patients so treated.

Adenocarcinoma of the esophagus is even more a male dominant disease than stomach cancer. This tumor may arise both from the mucosa of the gastric cardia and from the esophageal lining as has been recorded with Barrett's esophagus. Again, surgery is the most effective treatment, but the operative mortality rate too closely approximates the cure rate. Operative intervention aimed at a lower morbidity rate but obtaining the same palliative result may yield as good an overall cure rate.

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Liver transplantation and Wilson's disease

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We report on a 17-year-old girl with Wilson's disease who had hemolysis and fulminant hepatic failure with a normal ceruloplasmin but was ultimately found to have a highly elevated urinary copper and Kayser-Fleischer rings. Because of the high mortality of fulminant hepatic failure and hemolysis at the time of onset of significant encephalopathy in previous studies, the patient was referred for liver transplantation. On hospital day 5, an orthotopic liver transplantation was done. The patient survived the operation and continues to do well nearly three years later. This case demonstrates the importance of further investigation for Wilson's disease in patients with normal ceruloplasmin levels and the ability to successfully perform orthotopic liver transplantation for fulminant hepatic failure in Wilson's disease.

FULMINANT HEPATIC FAILURE is a rare but lethal complication of Wilson's disease. Hemolysis frequently accompanies this condition. Although medical therapy is effective for the chronic hepatitis of Wilson's disease, it is too slow in onset to provide effective treatment in these acute cases. Sternlieb[1] has suggested that orthotopic liver transplantation is the only effective therapy for this subset of patients. The increase in the number of liver transplantation centers makes it possible for more of these patients to benefit from rapid diagnosis and definitive treatment of fulminant Wilson's disease. We present a case of Wilson's disease complicated by sudden and severe hepatic failure that was promptly and successfully treated with orthotopic liver transplantation.

Case history

The patient, a 17-year-old girl, was in good health until ten months prior to hospital admission, when intermittent crampy abdominal pain developed. A local physician diagnosed a ruptured ovarian cyst; she was eventually hospitalized for removal of her appendix.

The symptoms persisted, however. Six months prior to admission, laboratory evaluation showed the following: SGOT, 122 IU/L; gamma glutamyl transpeptidase (GGT), 249 IU/L; alkaline phosphatase, 200 IU/L; total bilirubin, 0.7 mg/dL; albumin, 2.9 g/dL; and lactase dehydrogenase (LDH), 266 IU/L. Tests for antibodies to hepatitis A were negative, as were those for markers for hepatitis B (anti-HBsAg, anti-HBcAg, HBsAg). A monospot test was positive, and the diagnosis of Epstein-Barr virus (EBV) hepatitis was considered.

Five months prior to hospital admission, the SGOT value was 83 IU/L, and abdominal ultrasound revealed splenomegaly and normal biliary tree without gallstones or dilation.

The patient continued to have primarily epigastric abdominal pain and malaise.

One month before admission, results from a hepatobiliary scan were normal. The total bilirubin level was 1.5 mg/dL.

Two weeks prior to admission, the patient developed intermittent fever with chills and a frontal throbbing headache. Tests for hepatitis A and B were again negative, as was an antinuclear antibody test, and results of a gynecologic evaluation were normal. Nausea and vomiting developed. Liver function studies performed one week before the patient was admitted showed total bilirubin, 7.5 mg/dL; SGOT, 143 IU/L; SGPT, 67 IU/L; and alkaline phosphatase, 31 IU/L. The patient was admitted for further evaluation.

The patient's medical history was unremarkable, and she apparently had not used alcohol or had blood transfusions. Birth control pills were taken briefly for eight months prior to admission for menorrhagia; otherwise she took no medications. She was one of ten children in the family, the rest of whom were in good health.

The physical exam showed the patient to be an icteric, ill young woman. Her temperature was 38 °C. Neither spider angiomata nor Kayser-Fleischer rings were apparent during the initial exam. A grade II/VI systolic ejection murmur was present. Hepatosplenomegaly was evident with mild, diffuse tenderness. A guaiac test on the stool was negative and results from a neurologic exam were within normal limits.

Laboratory tests revealed the following: hematocrit, 30%, with macrocytosis and polychromasia; platelet count, 147,000/μL; prothrombin time (PT), 17.8 seconds; partial thromboplasm time (PTT), 36.8 seconds; SGOT, 182 IU/L; alkaline phosphatase, 63 IU/L; total bilirubin, 31.2 mg/dL, with a direct component of 27.2 mg/dL; albumin, 2.6 g/dL; uric acid, 1.7 mg/dL; and ceruloplasmin, 37 IU/L (normal is 35 to 85).

Within 24 hours, the hematocrit fell to 20% with an increase in total bilirubin to 42 mg/dL. Tests revealed the following: platelet count, 99,000/μL; reticulocytes, 11%; hemoglobinuria; haptoglobin, absent; Coombs test,

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negative; fibrinogen, 255 mg/dL (normal is 150 to 350); and no red blood cell fragments on a peripheral smear. Serum copper was elevated at 342 μg/dL (normal is 85 to 155), and the urine copper excretion for 24 hours was 4,653 μg (normal is 15 to 60). Transfusions of packed red blood cells were given. Slit lamp examination revealed Kayser-Fleischer rings. Ascites developed and the bilirubin level rose to 50 mg/dL. The patient became mildly encephalopathic with a rising serum ammonia level.

Because of the patient's rapidly deteriorating condition, we initiated a call for a donor liver three days after her admission, and she underwent orthotopic liver transplantation two days later. A sample from the patient's severely cirrhotic liver contained 1,211 μg of copper per frame of dry liver tissue weight (normal is 18 to 45 μg/g). Analysis of the patient's nine siblings revealed asymptomatic Wilson's disease in two, confirmed by liver biopsy; one had Kayser-Fleischer rings.

The patient continues to do well. Results of liver function tests (alkaline phosphatase level of 76 IU/L, SCOT level of 20 IU/L, GGT at 18 IU/L, bilirubin level of 1.1 mg/dL), urine copper studies (29 μg over 24 hours), and examination of the patient's ceruloplasmin level are all normal nearly three years after transplantation.

Discussion

Liver disease is the primary symptom in less than half of Wilson's disease sufferers. These patients usually have acute or chronic active hepatitis or cirrhosis, with most showing symptoms of the disease by the age of 30 and few before age 6. The fulminant liver failure we describe here is much less common.

Several reports have outlined the dismal prognosis of this complication.[1-3] In this patient, mild hepatitis was present initially and multiple diagnoses were considered before rapid deterioration led to her hospitalization. Serum ceruloplasmin concentration in this patient was low normal, which has been found in up to 15% of patients with hepatic Wilson's disease.[2]

Several characteristic features of hepatic failure from Wilson's disease, as outlined by McCullough et al,[4] were present, including modest elevations of aminotransferase and normal to minimally elevated levels of alkaline phosphatase in the face of severe liver failure and very high bilirubin levels. Also indicative of Wilson's disease was the occurrence of active intravascular hemolysis with elevated serum copper.[3-5] The marked cupriuresis and abnormal results from the slit lamp examination led to the correct diagnosis.

Recent literature reviews list ten patients with well-documented acute liver failure and hemolysis, all of whom died.[3,4] Another patient died after four months, following initial improvement with the use of oral D-penicillamine that forestalled liver transplantation.[6] This combination of hepatic failure with acute intravascular hemolysis in Wilson's disease portends a grave prognosis, usually leading within days to hepatic coma and death despite early specific and aggressive medical therapy.[7-9]

A case recently reported by Sokol et al[9] was exceptional in that it documented survival of fulminant hepatic Wilson's disease after nearly two weeks of intensive medical support prior to the liver transplant. Another patient, reported by Takela et al,[10] was managed successfully with the use of oral D-penicillamine and continuous arteriovenous hemofiltration to remove the copper. Combined liver and kidney transplantation was required, however, when the patient failed to improve after nearly two months of treatment. Most patients have died within six to ten days after admission with a mean total duration of illness prior to death of 17 days. Together, these cases demonstrate the efficacy of orthotopic liver transplantation in what previously was a uniformly fatal form of Wilson's disease. Furthermore, the case presented here confirms the usefulness of the biochemical profile outlined by McCullough et al[4] in differentiating Wilson's disease from other causes of fulminant hepatic failure.

Liver transplantation should be considered the treatment of choice in fulminant hepatic Wilson's disease as undue diagnostic and therapeutic delays may prove fatal in this setting.

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Group C streptococcal arthritis

James R. Davidson, MD, and Walter R. Sundstrom, MD, Madison

Lancefield Group C streptococcal infections in humans are rare, but when they do occur they are frequently severe. This organism, although universally susceptible to penicillin in vitro, frequently displays tolerance to this drug. We report on a patient with Group C streptococcal arthritis and present a review of the literature along with a discussion of therapeutic implications.

LANCEFIELD GROUP C streptococcal infections in humans are uncommon. These organisms, however, have been demonstrated to cause endocarditis,[1-3] purulent pericarditis,[4] cellulitis,[2-5] pneumonia with empyema,[6] meningitis,[2,3] pharyngitis,[7] epiglottitis,[8] glomerulonephritis,[9] and, in three previously reported cases, septic arthritis.[10-12] We report a fourth case of septic arthritis produced by Group C streptococci and review the literature regarding pathogenicity and tolerance.

Case report

A 71-year-old man was hospitalized with right shoulder pain. Two weeks prior to admission he had sustained an injury to his right shoulder. One week before admission, an oral temperature of 39.6 °C was noted. A roentgenogram of the shoulder revealed superior migration of the humeral head with narrowing of the humeral-acromion space. Over the ensuing week, progressive pain and swelling developed in the right shoulder.

On physical examination the patient had an oral temperature of 35.8 °C. A grade 3/6 holosystolic mitral regurgitant murmur was present. There was no evidence of cutaneous or nail emboli and splenomegaly was not present. Mentally, the patient was oriented as to place and person, but not time. Examination of the right shoulder revealed the presence of a large, warm, and tense anterior and posterior effusion. Motion was painful and revealed crepitation. The remainder of the physical exam was unremarkable.

An examination of the patient's medical history revealed that he suffered from an esophageal stricture, depression, and coronary artery disease, and had undergone bypass graft surgery and a below-the-knee amputation of the left leg due to peripheral vascular disease. Synovial fluid aspirated from the right shoulder was grossly purulent. The WBC was 136,000/μL with 98% polymorphonuclear leukocytes. Results of a crystal examination were negative, and a gram stain revealed numerous gram-positive cocci in clusters. The urinary sediment contained three to five white blood cells per high-power field with negative culture, and urobilinogen was present. The creatinine level was 1.7 mg/dL, BUN, 38 mg/dL, and WBC, 12,800/μL, with 84% polymorphonuclear leukocytes and eight band forms. The hemoglobin level was 10.6 g/dL. A chest roentgenogram on admission showed pleural calcification and a mildly enlarged cardiac silhouette, and an electrocardiogram revealed a sinus rhythm with first degree block. Synovial fluid and three blood cultures grew Group C beta-hemolytic streptococci sensitive to penicillin. The minimal inhibitory and mean bactericidal concentrations for penicillin were less than 0.06 μg/ml. Serum bactericidal levels revealed killing activity at a serum dilution of 1:512. Initial empiric antibiotic therapy consisted of intravenous nafcillin, 2 grams every four hours. After the sensitivities were know, antibiotic therapy was altered to intravenous penicillin G, 12 million units per day.

The patient remained afebrile. Subsequently, all blood cultures were negative. Daily arthrocentesis of the shoulder revealed decreasing white blood cell counts with persistently negative cultures after the seventh day. Echocardiography on the second hospital day showed mitral valve calcification, aortic sclerosis, and no evidence of vegetations. No repeat echocardiograms were done.

On the 19th hospital day, the patient had a precipitous onset of dyspnea and congestive heart failure. Despite aggressive medical management, he became unresponsive and died. Permission for a post-mortem examination was not obtained.

Discussion

Lancefield Group C streptococci are common veterinary pathogens capable of producing septicemia and arthritis in young swine, strangles and equine pneumonia and bovine mastitis.[13] Zoonotic transmission of the disease has been suspected.[13] The organisms' involvement in the pathogenesis of human disease has been suspected for 40 years,[14] but only recently has the severity of disease

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produced by these organisms been recognized.[2,15]

In a retrospective review of 150,000 blood cultures over a ten-year period, Mohr et al[2] found that 2,600 (1.7%) were positive for streptococci and eight (0.3%) of these isolates were Group C. Two of these eight isolates were felt to be contaminants. Similarly, in a large series of human streptococcal infections, Rantz and Keefer[14] reported that only 1.2% were due to Group C.[14] Duma reported that in 140 cases of streptococcal bacteremia, Group C was isolated in only one.[15] Differentiation of this subgroup of streptococci from other subgroups has been difficult.[16,17] Group C streptococci are beta-hemolytic and often display bacitracin sensitivity, as do Group A streptococci. In addition, other streptococci, such as *S sanguis* or *S milleri* may agglutinate with Group C antisera.[16] Biochemically, DNA-DNA hybridization tests have shown that *S equisimilis,* (a Group C streptococcus), large colony Group G streptococci, and Group L streptococci may represent a single species.[17]

Proper identification of Group C streptococci is critical. The organisms frequently display tolerance to penicillin in vitro.[18] Poitnoy et al, in a study of 17 clinical isolates of Group C streptococci,[18] found that for 16 the mean bactericidal concentration of penicillin was 32 or more times greater than the corresponding minimal inhibitory concentration (MIC). The MIC was uniformly low, ranging from 0.02 to 0.15 U/ml. In this study, marked synergy for in vitro bacterial killing was observed with a combination of penicillin and gentamicin. The investigators showed complete killing of clinical isolates after a five-hour incubation with penicillin and gentamicin, whereas viable organisms were recovered in all samples after incubation periods up to 48 hours when the drugs were used individually. Whether tolerance is clinically in vivo remains unknown.

The serious nature of Group C streptococcal infection should not be minimized. In his review of endocarditis cases, Mohr found that four of nine patients died while being treated with appropriate antibiotics.[2] Group C streptococcal pneumonic infections characteristically produce pleural effusions,[2,6] and empyema has also been documented.[6] In three previously reported cases of Group C streptococcal arthritis, one patient required a subtotal talectomy[12] and two patients had radiographic evidence of destructive arthritis due to the infection, although they were medically cured.[10,11] All three patients were treated with penicillin or penicillin derivatives. None of the articles reported the presence of MIC or bactericidal titers (see Table).

Our case confirms the serious nature of this apparently treatable infection. We believe this case represented a primary bacteremia from an unknown source complicated by suspected endocarditis and documented septic arthritis. Although the septic arthritis seemed to respond to penicillin therapy, the patient died, presumably from cardiac complications. Notably, the particular organism involved with this patient's infection did not display tolerance to penicillin. This suggests that tolerance is not a prerequisite for the virulence displayed by this organism. Because of the morbidity and mortality associated with Group C streptococcal

Group C streptococcal arthritis in four patients

Patient	*Age*	*Sex*	*Location*	*Predisposing Conditions*	*Treatment*	*Outcome*
1	53	M	Right first MTP	Diabetes Gout Hypertension Dexamethasone	Nafcillin Ampicillin Penicillin	Bony erosion Extended inflammation "Cured"
2	21	F	Left first MTP	Granulomatous colitis Pharyngitis Overlying callous	Penicillin	Bony erosion "Cured"
3	13	M	Right ankle	Hereditary Sensory Neuropathy Charcot Arthropathy	Penicillin Surgical drainage Subtotal talectomy	Ambulating with orthotics "Cured"
4	71	M	Right shoulder	Mitral Regurgitation Colonic cancer Peripheral vascular Disease	Nafcillin Penicillin	Died

infection, we recommend aggressive antibiotic management. If Group C streptococci are isolated, the addition of an aminoglycoside to penicillin therapy for synergistic bacterial killing is suggested until in vitro methods can determine whether the organism is tolerant.

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Clinical cancer: 29

Cancer of the unknown primary site

Charles H. Diggs, MD, Madison

CANCER OF UNKNOWN PRIMARY site is a relatively common clinical problem. Estimates of its incidence range from 0.5% to 15%,[1,2] and it is said to be the eighth most common form of malignancy. Because the physician faces obvious difficulties in managing a patient with metastic malignancy having no obvious primary site, this paper will review the problem and discuss various evaluation and treatment approaches.

The definition of carcinoma of an unknown primary site has varied based on the thoroughness of the evaluation performed after carcinoma has been documented in a metastatic site. A metastatic malignancy is usually said to be of unknown primary site when it has been proven by biopsy of an area not likely to have given rise to a primary malignancy of that histologic type and when a thorough history, physical examination, blood tests, and radiologic evaluations have failed to reveal evidence of a primary tumor. Of patients whose clinical course satisfies this definition, primary neoplasms will only be found in approximately 15% even after autopsy studies.[1]

Diagnosis

The diagnosis of metastatic carcinoma of an unknown primary site rests on biopsy-proven evidence of malignancy as defined above. Patients will have many different sites of metastasis and it is important to consider these sites when attempting to discover the primary lesion. The major distinction to be made is whether the sites are supradiaphragmatic or infradiaphragmatic since lung cancer is statistically more likely to be the primary tumor when disease

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occurs above the diaphragm and pancreatic carcinoma is more frequent in disease below the diaphragm. These sites may include: cervical, axillary, supraclavicular or inguinal lymph nodes; liver metastases; lung nodules or pleural effusion; brain metastases; or bone or bone marrow metastases.

Regardless of the site, the histological pattern of the metastases is important in determining the likelihood of certain primary sites and may also may help direct further work-up. It would, therefore, seem prudent to perform a biopsy of the affected area as the first step. This may also help prevent unnecessary evaluation, since certain histologic patterns may be inconsistent with origins in various organs (eg, squamous carcinoma in a cervical lymph node and a gastrointestinal primary site).

In general, three histologic patterns may be found in patients having carcinomas of an unknown primary site. These are squamous carcinomas, adenocarcinomas, and a group that cannot be further classified other than as undifferentiated carcinoma. In this latter group, lymphomas, melanomas, or germ-cell carcinomas might be included along with extremely poorly differentiated adenocarcinoma. It is frequently helpful for the clinician to consult with the pathologist reading the biopsy since it may be possible to narrow the list of possible primary sites. It is also likely that immunocytochemistry studies have been done, helping to direct further work-up. These cytochemistry stains may include antigens for melanoma, germ-cell tumors, prostatic carcinoma or CEA. It is also important to have obtained estrogen receptor tests in women patients with adenocarcinoma of an unknown primary site in order to diagnose possible breast cancer.

Evaluation

The extent of the required evaluation of a patient with carcinoma of an unknown primary site has been somewhat controversial. Since most patients' primary cancers will not be identified and since the expected survival time of these patients averages less than six months,[1,3] an extensive search for a primary tumor frequently is unrevealing, yielding only discomfort to the patient and generating more cost than is necessary. A directed work-up, however, would seem appropriate with its direction determined by the clinical symptoms, the histological subtype of cancer documented, and the location of the metastasis.

As with any illness, completion of a thorough medical history with attention to risk factors (smoking, occupation exposures, history of drug use, etc) and a physical examination with particular attention to all sites of further metastasis or possible primary sites are first steps. Following completion of the history and physical examination, a variety of blood tests can be obtained in addition to the standard hematologic and chemical evaluation. If an adenocarcinoma is found in a man, a prostatic acid phosphatase test should be performed. A CEA may also be valuable in that circumstance. In women with adenocarcinomas, a CEA and CA-125 may be valuable. Serum levels of beta HCG and alphafetoprotein may be useful in evaluating the primary site for an undifferentiated carcinoma, although carcinomas other than those of germ-cell origin may occasionally give rise to elevations of these markers. Testing of the stool for occult blood should be performed in all patients.

Radiographic evaluation of the patient with carcinoma of unknown primary site is less likely to be beneficial. In one study, an upper gastrointestinal series, barium enema and intravenous pyelogram, detected tumors in only 22 of 603 examinations, for a yield of less than 5%.[4] Therefore, it is not cost effective to perform these evaluations unless there is a high degree of suspicion that the organ is likely to be involved. The histology of the metastasis, the patient's symptoms, and the results of stool tests for blood will help determine whether these procedures should be performed. Abdominal CT scanning, has been shown, however, to be of higher yield in this patient group. A 32% true positive rate (31 of 98 patients) was found in a study by Carsell,[2] and the pancreas was identified as the primary site in more than one third of these. It would, therefore, seem reasonable to include an abdominal CT scan as part of the initial evaluation.

Expected responses to treatment

Cure possible:
- Germ cell tumors
- Hodgkin's disease
- Lymphomas
- Choriocarcinoma

Good palliation (>50% response):
- Bladder cancer
- Breast cancer
- Ovarian cancer
- Prostate cancer
- Uterine cancer
- Head and neck cancers
- Small cell lung cancer

Fair palliation (<50%):
- Colon cancer
- Sarcoma
- Stomach cancer

No effective therapy:
- Lung (non-small cell) cancer
- Pancreatic cancer
- Renal cancer
- Melanoma
- Esophageal cancer

Treatment

The treatment of carcinoma of an unknown primary site has generally been unrewarding. One series of patients treated with a variety of modalities showed little improvement in survival time especially in those who had metastatic adenocarcinoma with no primary site identified.[3] Another group, however—those with a squamous carcinoma found in cervical lymph nodes and treated with surgery, radiotherapy or both—showed a greater than 50% survival rate at three years.[1] This subgroup of

patients seems clearly to benefit from such treatment and should be aggressively managed.

The larger group of patients with unknown primary tumors—ie, those with an adenocarcinoma or undifferentiated carcinoma—have diseases that are much more difficult to control. Since survival times in these patients are brief and since most will require combination chemotherapy because of the extent of disease identified at the time of diagnosis, the toxicities of such therapy must be weighed against the expected results. Although there are certain diseases that can be treated by combination chemotherapy (see Table), most patients with carcinomas of an unknown primary site do not fall into these categories. Patients with a metastatic adenocarcinoma treated with combination chemotherapy were evaluated in a study by the Southwest Oncology Group[3] with no tumor response seen in 36 patients treated with either 5-fluorouracil (5-FU) or 5-FU, doxorubicin and cyclophosphamide. The median survival time in both groups was approximately 100 days with 75% of the patients having some toxicity from the therapy.

Undifferentiated carcinomas, especially those with elevated beta HCG, alphafetoprotein, or both, have also been treated with combination chemotherapy, including cisplatin.[5] Although some initial tumor response was seen, no cures were accomplished, suggesting that malignancies were indeed not germ-cell tumors. Undifferentiated carcinomas suggesting lymphoma may effectively be treated with combination regimens designed for large-cell lymphomas.

Because of considerations previously discussed, namely generally poor response rates and no improvement in survival times, treatment of the patient with carcinoma of an unknown primary site should be directed toward relief of symptoms. If pain is present in a metastatic site, radiotherapy may be an effective form of relief. CNS lesions may benefit by debulking surgery followed by radiation therapy, and the patients with pleural effusions may have their symptoms lessened by thoracentesis or pleural sclerosis. Effective pain medications, including oral or intravenous narcotics, might also be effective as might emotional and family support including hospice intervention.

Summary

The patient who has a metastatic carcinoma of an unknown primary site presents a major clinical problem. It is difficult for the physician to decide how much evaluation is enough and how much is too much, especially in these times of rising medical costs. Although specific patient groups may benefit from aggressive therapy, the large majority have not been shown to and are best treated by controlling the symptoms of the disease. Quality of life rather than duration of survival will be the most important consideration for these patients.

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Hepatitis B screening

Routine screening of all pregnant women for the hepatitis B surface antigen (HBsAg) is now recommended by the Center for Disease Control's Advisory Committee on Immunization Practice (ACIP). A recent issue of *Morbidity and Mortality Weekly Report* (Vol 37, No. 22) says the ACIP has reversed its 1984 recommendation of screening only high-risk women because the policy apparently has not been successfully implemented. The report cites several studies suggesting that only 35% to 65% of HBsAg-positive pregnant women are being identified under the old guidelines.

Transmission of hepatitis B virus (HBV) from mother to fetus during the prenatal period is one of the most efficient modes of infection, according to the report, and 70% to 90% of infants born to HBV-infected mothers will become chronic HBV carriers.

The committee recommends testing women early in their pregnancies, when other routine screening tests are ordered. A woman who has not been tested during her pregnancy should be screened when she is admitted to the hospital, the committee says.■

Family over money

Money is not the top motivator for students choosing medical specialties, according to *Medical Economics*. When faced with this decision, a large majority of the students place the greatest value on having enough time for family and private life. Less than 30% cite money as the main consideration.■

Special

Peritonitis in children with nephrotic syndrome

Mark Mannenbach, Heinz Leichter, MD, and Kumudchandra Sheth, MB
Milwaukee

We reviewed the charts of all patients with the diagnosis of nephrotic syndrome complicated by primary peritonitis admitted to Children's Hospital of Wisconsin between 1975 and 1987. During this 12-year-period, ten children with nephrotic syndrome with 19 episodes of peritonitis were admitted. Four patients (40%) had repeated episodes. The predominant organisms found were gram-positive bacteria (47%) followed by gram-negative organisms (22%). Thirty-one percent of all cultures were negative. Antibiotic treatment was salutary in all patients, and none died of complications. Immunologic and genetic factors seem to play a role in cases of repeated episodes of peritonitis.

NEPHROTIC SYNDROME is a well-described entity involving edema, proteinuria, hypoalbuminemia, and hypercholesterolemia. Complications of nephrotic syndrome include hypovolemia, thrombosis, and a variety of infections of which peritonitis is the most serious. The first report of a fatal case on pneumococcal peritonitis in a patient with nephrotic syndrome was described as early as 1914 by Volhard et al.[1] Consecutive reports[2-5] confirmed the increased risks of patients with nephrotic syndrome for the development of this potential lethal complication.

In our retrospective study, we review our experience over a 12-year period with primary peritonitis in nephrotic syndrome and evaluate predisposing factors, pathogenic organisms, complications and prognosis.

This paper was an entry in the student writing contest sponsored by the *Wisconsin Medical Journal*. Mannenbach is a student at the Medical College of Wisconsin in Milwaukee. Drs Leichter and Sheth are with the Division of Pediatric Nephrology at Children's Hospital of Wisconsin. Reprint requests to: Mark Mannenbach, 8317 Watertown Plank Road, Wauwatosa, WI 53213 (telephone: 414-771-4139). Copyright 1988 by the State Medical Society of Wisconsin.

Methods

We reviewed all charts of patients with the diagnosis of nephrotic syndrome and primary peritonitis admitted to Children's Hospital of Wisconsin between 1975 and 1987. Nephrotic syndrome was defined as heavy proteinuria (>3 g/d on dipstick), hypoalbuminemia (<2.5 g/dL), hypercholesterolemia (>250 mg/dL) and edema. Peritonitis was defined by the clinical signs of abdominal pain, tenderness, and either peritoneal leukocytosis, and presence of a positive peritoneal or blood culture. In patients with more than one episode of peritonitis, each episode was considered. All values are expressed as mean plus or minus standard deviation (SD).

Results

Sixteen patients were diagnosed as having peritonitis with nephrotic syndrome, but because some patients had no peritoneal or blood cultures done prior to antibiotic therapy, fewer patients fulfilled the criteria for acceptance in our study.

Ten patients with the diagnosis of nephrotic syndrome developed one or more peritonitis episodes. Seven patients were determined to have minimal change disease based on the results of either biopsies (five patients) or on their symptoms and response to steroid therapy (two patients). Two patients had mesangial proliferative glomerulonephritis and one had Alport's syndrome with nephrotic syndrome. Of the ten patients, eight were boys and two were girls. Five patients were black, four were white and one was of Hispanic origin. The mean age at onset of the first episode was 5.83 ± 0.6 years (range = 2.6 to 11). A total of 19 peritonitis episodes occurred in these ten patients. Six patients had one peritonitis episode each, two had two episodes, one had three and one patient had six episodes.

Nine (47%) of the 19 episodes occurred in the months of October, November, or December. The mean time interval from diagnosis of the nephrotic syndrome to the first peritonitis episode was 19.9 ± 5.5 months (range = 2 to 63 months). Six patients (60%) had their first episode within the first year after the diagnosis of nephrotic syndrome was made.

All patients were in a nephrotic state when they acquired peritonitis. Abdominal pain and ascites were the predominant symptoms. Other symptoms included fever, anorexia, vomiting, and diarrhea (see Figure). In 14 of 19 epidodes (74%), the patients were undergoing steroid therapy when peritonitis developed. None of the patients had been treated with cytotoxic drugs. Of the four patients with recurrent episodes, two were on steroids with all episodes and two were on steroids in half of their episodes. The mean interval between the recurrent episodes was 18.6 ± 11.0 months (range = one to 101 months). One patient received pneumovax immunization after his second peritonitis episode.

Of the 19 episodes, organisms were isolated in 13 episodes (69%), while no organisms were isolated in six

(31%) despite clinical symptoms and peritoneal leukocytosis. Common organisms were: *Streptococcus pneumoniae,* seven (37%); *Escherichia coli,* 2 (11%); *Haemophilus influenzae* Type B, 2 (11%); α-streptococcus, one (5%); and Group B streptococcus, one (5%). Organisms were isolated from both blood and peritoneal fluid in six episodes. In four episodes, only blood cultures were positive (see Table). All of the patients were initially treated with ampicillin 200 mg/kg divided into four doses and gentamicin 6 mg/kg divided into three doses. After the sensitivities of the bacteria in peritoneal or blood cultures were determined, antibiotics were adjusted appropriately. (In our patients, 48% of the infections were found to be from gram-positive organisms.) All of the patients defervesced within 48 hours; length of treatment ranged from 10 to 14 days.

Discussion

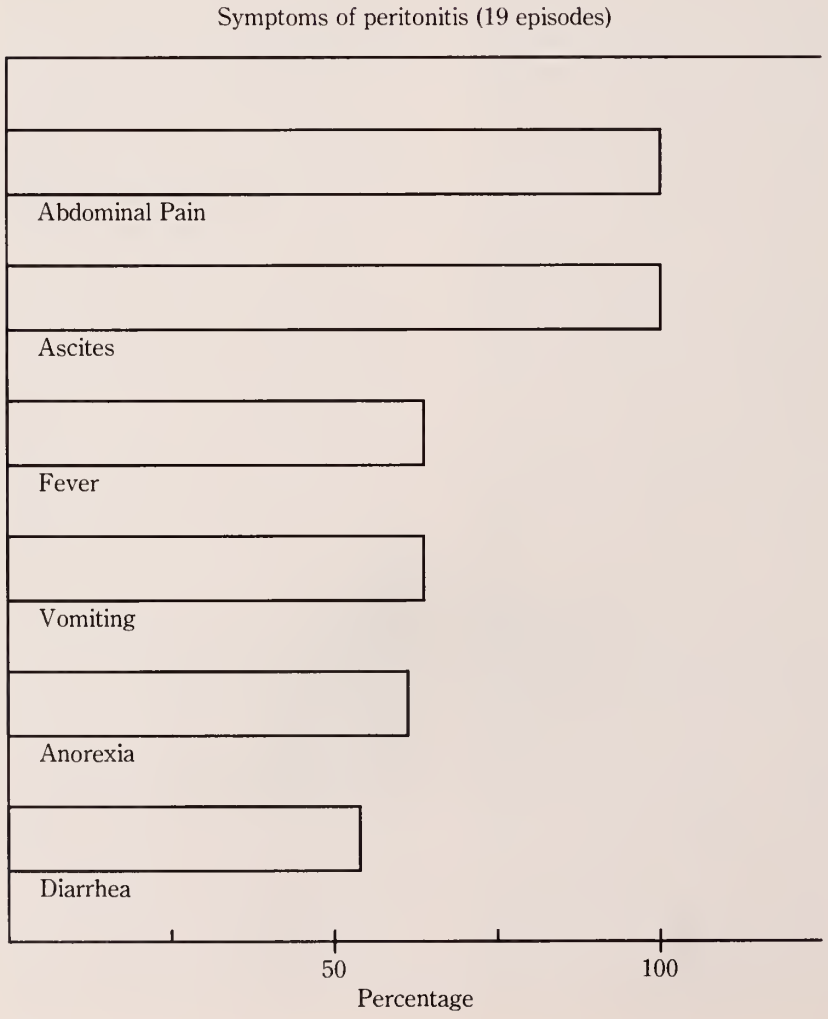
Our results are similar to those of Krensky et al[2] and Harker et al[4] who found *S pneumoniae* in 50% and 49% of their patients with nephrotic syndrome, respectively. Following the introduction of steroids for the management of childhood nephrotic syndrome and the broader use of antibiotics, the incidence of infections due to gram-negative organisms has increased. Speck et al[5] noted that in 22 of 26 patients (84.6%) with peritonitis prior to 1960, gram-positive cocci were isolated, whereas the same was true for only six of 11 (54.5%) from 1960 to 1972. Therefore, when peritonitis is found, broad spectrum antibiotic coverage for gram-positive and gram-negative bacteria is necessary. Adjustments can be made when culture and sensitivity results are available.

The predominant symptoms in our patients were abdominal pain, tenderness, and fever. Peritonitis should always be considered in a patient with nephrotic syndrome who complains of abdominal pain. Surgery should be avoided because it carries a considerable risk; in one report,[4] the patient died from emergency surgery.

The predominance of boys and the age range in our study population reflect the sex distribution and age pattern of childhood minimal change nephrotic syndrome. Although there was no racial predilection on the incidence of single episodes of peritonitis, repeated peritonitis episodes were frequent in non-whites. This increased incidence of peritonitis in black patients has been confirmed by others.[3,4]

Many factors play a role in the pathogenesis of peritonitis. Relapse of the nephrotic syndrome appears to be an important risk factor. All of our patients were nephrotic and had edema as well as ascites. This is in concordance with the findings of others.[3,5]

Since approximately 32% of our patients were on no immunosuppressive medication, the use of steroids is probably not necessary to acquire peritonitis. Repeated episodes even occurred in patients who were not on prednisone. Reduced circulating IgG levels due to increased urinary losses may predispose the patient to infection. Harken et al[2] found subnormal levels in 75% of their peritonitis patients and Krensky et al[4] found significantly lower levels when he compared 14 cases of peritonitis with an age-matched control group of nephrotic syndrome with relapse but no peritonitis. Unfortunately, only one of our patients had undergone immunoglobulin level testing. Depressed levels of some of the alternate complement pathway components also seem to predispose to infections as has been shown in extensive studies.[6,7]



The duration of the patient's disease also seems to play a role in acquiring peritonitis. Isolated reports indicate a higher risk[5] and mortality[8] if the peritonitis episode occurs within the first year of diagnosis. The increased mortality could not be substantiated by our findings. None of our patients died whereas in other reports, the mortality rate ranges from 0% to 20%.[5,9] The lower mortality rate found in our study is probably related to the early initiation of treatment with broad-spectrum antibiotics in these patients. Prevention of peritonitis with pneumococcal vaccine has been recommended,[10] yet only one of our patients received this immunization, and it was not effective in preventing further episodes. This could be due to an infection with a pneumococcal type that is not represented in the vaccine.

In summary, peritonitis continues to be a problem in patients with nephrotic syndrome, despite improvement in antibiotic treatment and prophylaxis with vaccines. Appropriate diagnosis and broad spectrum, antibiotic treatment can minimize life threatening complications.

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Patient and clinical data of 19 peritonitis episodes

*Pt**	*Race*	*Sex*	*Diagnosis*	*Treatment*	*Peritonitis Epidose #*	*Leukocytosis in Peritoneal Fluid*	*Blood Culture*	*Peritoneal Culture*
1	Black	M	MCD†	Yes	1	Yes	S Pneumo	S Pneumo
				Yes	2	Yes	NG‡	NG
				No	3	Yes	NG	S Pneumo
				No	4	Not done	S Pneumo	S Pneumo
				No	5	Not done	S Pneumo	S Pneumo
				Yes	6	Yes	S Pneumo	S Pneumo
2	Black	F	MESPGN§	Yes	1	Yes	E coli	E coli
				No	2	Yes	α-strep	NG
3	Black	M	Alport's	No	1	No	GP B strep	GP B strep
4	Black	M	MESPGN	Yes	1	Yes	NG	H Influenza
				Yes	2	Yes	NG	NG
5	Black	M	MCD	Yes	1	Yes	H Influenza	NG
				Yes	2	Yes	NG	NG
				Yes	3	Yes	S Pneumo	NG
6	Hisp	M	MCD	Yes	1	Yes	E coli	NG
7	White	F	MCD	No	1	Yes	NG	NG
8	White	M	MCD	Yes	1	Yes	NG	NG
9	White	M	MCD	Yes	1	Yes	NG	NG
10	White	M	MCD	Yes	1	Yes	NG	S Pneumo

*Pt = patient
†MCD = minimal change disease
‡NG = no growth
§MESPGN = mesangioproliferative glomerulonephritis

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Physicians and the Prescription Drug Marketing Act

Physicians' rights to use and distribute drug samples to patients are not affected by the new Prescription Drug Marketing Act, which is effective Oct 21, 1988, according to Gerald J. Mossinghoff, president of the Pharmaceutical Manufacturers Association.

Signed into law by President Reagan in April, the act establishes new requirements for the distribution and marketing of prescription drugs. Of special interest to physicians are provisions that prohibit the sale, trade or purchase of drug samples and require manufacturers that distribute samples to follow certain storage, handling and accounting procedures. Violators are subject to criminal penalties of up to ten years in prison and $250,000 in fines.

The Pharmaceutical Manufacturers Association advises physicians to keep the following in mind:

- The law does not prevent physicians from receiving or dispensing drug samples.
- To receive samples, physicians must sign a written request form verifying the identity of the drug and the quantity requested. This form is already required in some states and is commonly used by manufacturers.
- Although the law does not require physicians to maintain records, manufacturers may ask physicians for help in confirming that they did receive the samples requested.

According to Mossinghoff, the new law does not threaten the practice of providing drug samples, but does help safeguard the integrity of prescription drugs distributed in this manner.■

Medicare: questions and answers

Q. What situations require me to submit services on two separate claim forms?

A. You will need to submit two separate claim forms in the following situations:

1. Claims involving assigned and unassigned services. For example, Dr Smith submits a claim for a clinical lab and an office call. He accepts assignment for the clinical lab but not the office call.

2. Claims with services from more than one provider.

3. Claims involving more than 1 year of service. For example, Dr Smith submits a claim for eight hospital visits with dates of services from 12-29-87 to 1-5-88.

4. Claims submitted with more than 12 line items. (More than six line items for DME).

You will be informed on your EOMB when a claim has been split for processing.

Q. WPS–Medicare printed an order blank in the January/February issue of *Communique* to request profiles. Which profiles do I need and what do they tell me?

A. You may order a number of different profiles using the Freedom of Information request form found in the January/February issue of *Communique*.

Your 1988 Provider Pricing profile, which is called the Customary Profile on the order form, will provide you with a customary charge for all services you billed to Medicare at least three times during July 1, 1986, to June 30, 1987. It will also list the adjusted prevailing charge for each procedure for which you have a customary charge. The lower of the two figures is your reimbursement for calendar year 1988. You should compare your reimbursement figure to the amount you are approved on your Explanation of Medicare Benefits to

make sure you were paid correctly.

If a procedure code is not found on the Provider Pricing profile you will need to order an Area Prevailing profile to determine your reimbursement. The Area Prevailing profile lists the 50th Percentile and the Area Prevailing charge for all services in which physicians from the same specialty and locality have established a customary charge. The lower of the 50th Percentile and the Area Prevailing is your reimbursement. Like the Provider Pricing profile, you should use this profile to determine if you were paid correctly by Medicare.

The Base Period profile lists all charges for procedures you billed to Medicare from April 1 to June 30, 1984. The data found on this profile is used to determine the Maximum Allowable Actual Charge.

The Clinical Lab Fee Schedule lists columns of 60% and 62%. The 60% figure is your reimbursement for Clinical Labs performed in your office and the 62% figure is allowed for Clinical Labs performed in the outpatient department of a hospital.

Your request for profile should be sent to the attention of the Freedom of Information department.

Q. If I am not satisfied with the processing of my claim, can I appeal the decision? If so, what are the proper steps to take?

A. If you or your patient are dissatisfied with the processing of your claim, you may request a review. The review must be requested within 6 months from the date of the Explanation of Medicare Benefits. You should submit to Medicare a copy of the original claim, a copy of the Explanation of Medicare Benefits and any additional information which could alter the first decision, such as an operative report or progress notes. If Medicare continues to deny the claim, your may request a fair hearing if the amount in question is at least $100. This is calculated by taking 80% of the difference between the billed amount and the Medicare approved amount. The fair hearing must be requested within 6 months of the review determination.

If you are dissatisfied with the fair hearing you may appeal the carrier hearing officer's decision to an administrative law judge (ALJ) when the amount in controversy is at least $500. An ALJ Hearing must be requested within 60 days of the date of receipt of the fair hearing.

If you are dissatisfied with the ALJ hearing and the amount in controversy is at least $1,000 you may again request a judicial review before a federal district court judge.

If you have questions about Medicare that you would like to see answered in this column for the benefit of your peers, send them to: Medicare Q&A, c/o Karen Lord, State Medical Society of Wisconsin, PO Box 1109, Madison, WI 53701.■

A right to care

Ninety percent of American nonphysicians recently surveyed by Louis Harris & Associates said they viewed health care as a right. Only 68% of physicians surveyed agreed. (Reported in *American Family Physician.*)■

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ARMY RESERVE MEDICAL PROFILE NO. 5

ROSALYN P. STERLING-SCOTT, M.D.

Assistant Professor of Surgery, UCLA School of Medicine and Drew University of Medicine and Science, Los Angeles

Associate Surgeon, Department of Cardiovascular & Thoracic Surgery, Centinela Hospital Medical Center, Los Angeles

Major, U.S. Army Reserve

EDUCATION Rensselaer Polytechnic Institute, Troy, NY, B.S. Chemistry; NYU School of Medicine, New York, M.D.

RESIDENCY Boston University School of Medicine (Cardiovascular); Saint Vincent's and St. Claire's Hospitals, New York City (General Surgery)

FELLOWSHIP First Mary A. Fraley Cardiovascular Surgical Research Fellow at the Texas Heart Institute, Houston

OUTSTANDING ACHIEVEMENTS Author of numerous articles, including "Indications for Early Bypass Grafting Following Intracoronary Streptokinase"; author of "The Female Surgeon—Dawn of a New Era," chapter in *A Century of Black Surgeons—The U.S.A. Experience*; Board of Directors, Association of Black Cardiologists; Secretary, Drew Society

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Summary.
Consult the package literature for prescribing information.

Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae, Haemophilus influenzae,* and *Streptococcus pyogenes* (group A β-hemolytic streptococci).
Contraindication: Known allergy to cephalosporins
Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:
- Discontinue Ceclor in the event of allergic reactions to it
- Prolonged use may result in overgrowth of nonsusceptible organisms
- Positive direct Coombs' tests have been reported during treatment with cephalosporins
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include
- Gastrointestinal (mostly diarrhea), 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever), 1.5%, usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia

Abnormalities in laboratory results of uncertain etiology
- Slight elevations in hepatic enzymes
- Transient fluctuations in leukocyte count (especially in infants and children)
- Abnormal urinalysis, elevations in BUN or serum creatinine
- Positive direct Coombs' test
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly).

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Loss prevention corner

Medicare hospitals and emergency cases

In 1986 Congress adopted the Consolidated Omnibus Budget Reconciliation Act of 1985, also known as COBRA. This Act occupies more than 300 pages in the statute books. Tucked back under miscellaneous provisions is Section 9121 entitled "Responsibilities of Medicare Hospitals in Emergency Cases."

This appears to be a congressional attempt to deal with what is commonly called patient dumping—a serious problem, especially in metropolitan areas. While patient dumping has been roundly criticized, some critics of the Act say it carries the potential liability of hospitals and, to a lesser extent, physicians far beyond the wrong sought to be remedied.

The Act applies to any patient transfer where active labor or an emergency medical condition, as defined by the Act, exists. It further requires any hospital with an emergency department to provide for an appropriate medical screening examination for any person presented at the emergency department to determine whether active labor or an emergency medical condition exists.

As to any individual found to have an emergency medical condition or to be in active labor, the hospital must provide for further medical examination and treatment to stabilize the individual, or it must transfer the individual to another medical facility in accordance with the Act (generally, where the patient is not stabilized, this means that the patient, or a person legally responsible for the patient, must request the transfer or a physician must certify that the medical benefits of the transfer outweigh the risks).

If a patient is transferred without being stabilized, the hospital can be liable for damages or civil monetary penalties if any one or more of the following is true:

- A certification was not signed by the transferring physician at the time of transfer stating that the medical benefits of the transfer outweighed the risks;
- The means of transfer was not equipped or adequate to handle any foreseeable medical complications that might arise during transfer;
- The "transportation personnel" were not qualified to handle foreseeable medical complications;
- The transferring hospital did not contact the receiving hospital in advance to determine that adequate space for the patient and qualified staff were available;
- The transferring hospital did not obtain permission for the transfer from the receiving hospital in advance; or
- Copies of the patient's records were not provided to the receiving to the receiving hospital by the transferring hospital.

Serious penalties are provided for any violation of the Act. The hospital can have its provider agreement terminated or suspended. A civil monetary penalty can be imposed by the Secretary of HEW in an amount of up to $25,000 for each violation. In addition to civil monetary penalties assessed by HEW, an individual who suffers personal harm as a direct result of the hospital's violation of the Act may obtain "those damages available for personal injury under the law of the state in which the hospital is located" from the hospital. Presumably, the right to sue extends to the next of kin of the patient. Further, any other medical facility suffering a financial loss because of the transferring hospital's violation of the Act, may likewise obtain damages in a civil action.

The Act creates a strict liability against hospitals. Whether anyone was negligent has no bearing upon the

collectability of damages—all that must be proven is that the Act was in fact violated. In a very real sense, the Act erodes the independent contractor status of physicians on the medical staff. Under the Act, the hospital is responsible for the actions of the physician in determining whether a patient is stabilized and in signing the certification for transfer, without regard for the fact that the physician might be an independent contractor.

Not only does this have the effect of eroding the independent status of many physicians in the hospital, it also gives hospitals a potential argument to attempt to place further controls on the practice of medicine in the hospital. Critics charge, for example, that where a failure of a physician to certify in accordance with the Act results in liability to the hospital, it takes little imagination to conclude that the hospital's next act will be a lawsuit for indemnity against the physician. Hospitals may seek indemnity clauses in staff by-laws to deal with this situation.

From a reading of the Act, it appears that the liability for civil damages is that of the hospital. Physicians, however, are specifically made subject to the civil money penalties of up to $25,000 for failing to adhere to the provisions of the Act affecting physicians.

The Act has really not been interpreted by the courts, so there are many questions concerning its practical application and effect, but one seemingly innocuous provision of the Act may prove to be its greatest liability. The Act preempts any state or local law which directly conflicts with a requirement of the Act. Thus, within the context patient transfers, many if not all of the medical malpractice tort reforms which have been enacted by this and other states would be inapplicable. It will be up to the courts to determine how broadly to interpret the applicability of the Act (and thus its effect on tort reform), as to precisely what activities by physicians and hospitals constitute a patient transfer within the provisions of the Act.

Undoubtedly, the greatest initial burden is placed upon hospitals under the Act. Physicians, however, can become liable for civil penalties for not properly certifying a patient or for not properly screening.

Beyond the obvious problems, lurks the damage which the requirements of the Act could do to the relationship between physicians and hospitals. Disagreements could develop between physicians and hospitals over the identification of responsibilities under the requirements of the Act. For example, let us assume that a patient goes to the emergency room, and the emergency room physician determines that an emergency medical condition does not exist and that the patient should see his own physician in due course. Liability could arise under the Act if the patient's condition did in fact worsen and it was determined that the screening was not properly done.

It would appear to be incumbent upon both physicians and hospitals to be familiar with the provisions of this Act, and to institute appropriate procedures to ensure that the Act is not inadvertently violated. While the law is aimed primarily at patient dumping, it applies to any transfer in which the patient was not stabilized, regardless of whether the transfer was for economic reasons.■

Adapted with permission from the *South Dakota Journal of Medicine*. Written by David A. Gerdes, general counsel of the South Dakota State Medical Association.

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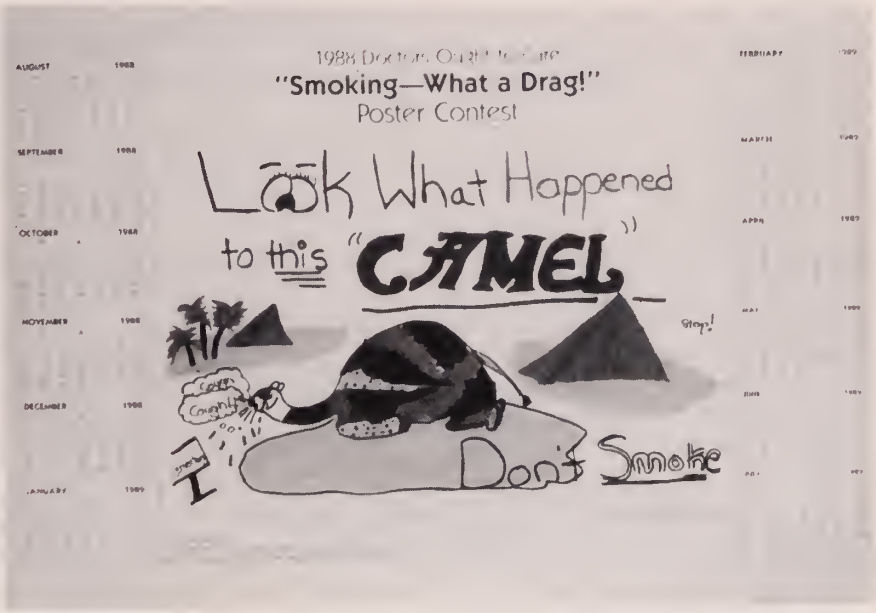
Medical students hold anti-tobacco art contest for kids

During the 1987–88 school year, Doctors Ought to Care initiated a pilot anti-tobacco advertising art contest open to all Dane County students in grades kindergarten through 8th. Doctors Ought to Care is a group of students from the University of Wisconsin Medical School dedicated to promoting healthy lifestyles among young people. The goal of the contest was to raise student awareness of the techniques used by tobacco companies to attract young smokers, and it attracted more than 500 entries from 15 schools.

Wisconsin Attorney General Don Hanaway presented awards to the winners and talked to the students and their parents about the importance of developing healthy lifestyles. The poster by Teresa Palumbo, a 6th grade student from Marquette Middle School in Madison, was selected as the best, and with the help of the SMS CES Foundation and the American Cancer Society, was made into a calendar that is being distributed to Dane County schools and businesses.

During the last six years, DOC members have spoken to thousands of Dane County middle and high school students about various health topics, including sexuality, eating disorders, alcohol and other drugs, suicide, and tobacco use.



The camel coughs: This calendar, based on the winning entry to the Doctors Ought to Care anti-tobacco advertising art contest, is being distributed to Dane County businesses and schools.

For more information, or a copy of the calendar, contact: Doctors Ought to Care, 1300 University Ave, Madison, WI 53706.■

News highlights

St Luke's Hospital of Racine recently announced that Dennis J. Kontra, MD,* has been elected chief of staff for 1988–89. Others elected to the executive staff are: Robert E. Drom, MD,* vice chief; James B. Shack, MD,* secretary; and Nasip H. Yasatan, MD,* treasurer.

Hudson Memorial Hospital recently named John Marnell of Edina, Minn, as hospital administrator. A New Jersey native, Marnell has a bachelor's degree in economics from St Peter's College in Jersey City, and a masters degree in hospital management from the University of Minnesota in Minneapolis. He was previously administrator of physician services for Riverside Medical Center in Minneapolis.

The Marshfield Clinic recently added the following physicians to its medical staff: Thomas B. King, MD, Thomas W. Schuepper, MD, and Ronald Rothfusz, MD.* A cardiologist, Dr King graduated from the Washington University School of Medicine and completed a residency at the Jewish Hospital in St Louis. Dr Schueppert is an orthopedic surgeon and received his medical degree from the Medical College of Wisconsin in Milwaukee. He completed a residency at St Francis Hospital in Peoria, Ill. Dr Rothfusz recently completed a residency at the clinic and St. Joseph's Hospital. He received his degree from the University of Wisconsin Medical School.

Neillsville Clinic, SC, has appointed Rod McLean of Neillsville as clinic administrator. McLean was most recently director of economic development for the City of Neillsville.

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Ask for Gary Baehman, Iola Hospital Administrator

Board of Directors takes action in Prairie du Chien

The SMS Board of Directors held its July meeting in Prairie du Chien in conjunction with the annual Civil War encampment sponsored by the Charitable, Educational and Scientific Foundation. The two-day encampment is held on the grounds of the Fort Crawford Medical Museum and attracts Civil War buffs from around the Midwest.

SMS board members heard a special presentation on the Harvard resource-based relative value scale (RBRVS) by Mark Segal, PhD, director of the AMA's Department of Health Care Financing. Segal told the board that the proposal was expected to be finished and sent to the Health Care Financing Administration (HCFA) near the end of September. It was to be made public at about the same time.

The RBRVS formula would establish a new national Medicare fee schedule for 18 medical specialties (15 more will be added to the study later) and was to be completed in mid-July, with release to the public a month later. The AMA is a subcontractor of the project.

In his presentation to the Board, Segal explained the various elements of the formula, which is being developed at Harvard University by William S. Hsaio, PhD, and associates. Segal also said the AMA staff will be meeting with state medical associations and specialty societies to explain the formula's impact and to get their feedback. According to Segal, the AMA House of Delegates is expected to take an official position on the RBRVS at its interim meeting in December. The study is expected to reach Congress around Jan 1, 1989, and, if approved, would be implemented sometime after Jan 1, 1990; Segal also said he expects any program approved by Congress to be phased in gradually.

During its lengthy meeting, the SMS Board also:

- Approved the proposed renovation of the SMS headquarters (see Secretary's Report, page 5);
- Accepted the recommendations of the PartnerCare Working Group raising the PartnerCare income guidelines to $12,500 for a single person and $16,500 for a couple, effective April 15, 1989 (these bring Wisconsin's eligibility limits in line with neighboring states' programs and are based on the state Homestead Tax Credit Program levels);
- Accepted a Membership Committee recommendation to increase SMS membership dues for medical students to $20 for four years and to charge a $40 annual subscription fee to dues-exempt members for the *Wisconsin Medical Journal* and *Medigram*;

Continued on page 35

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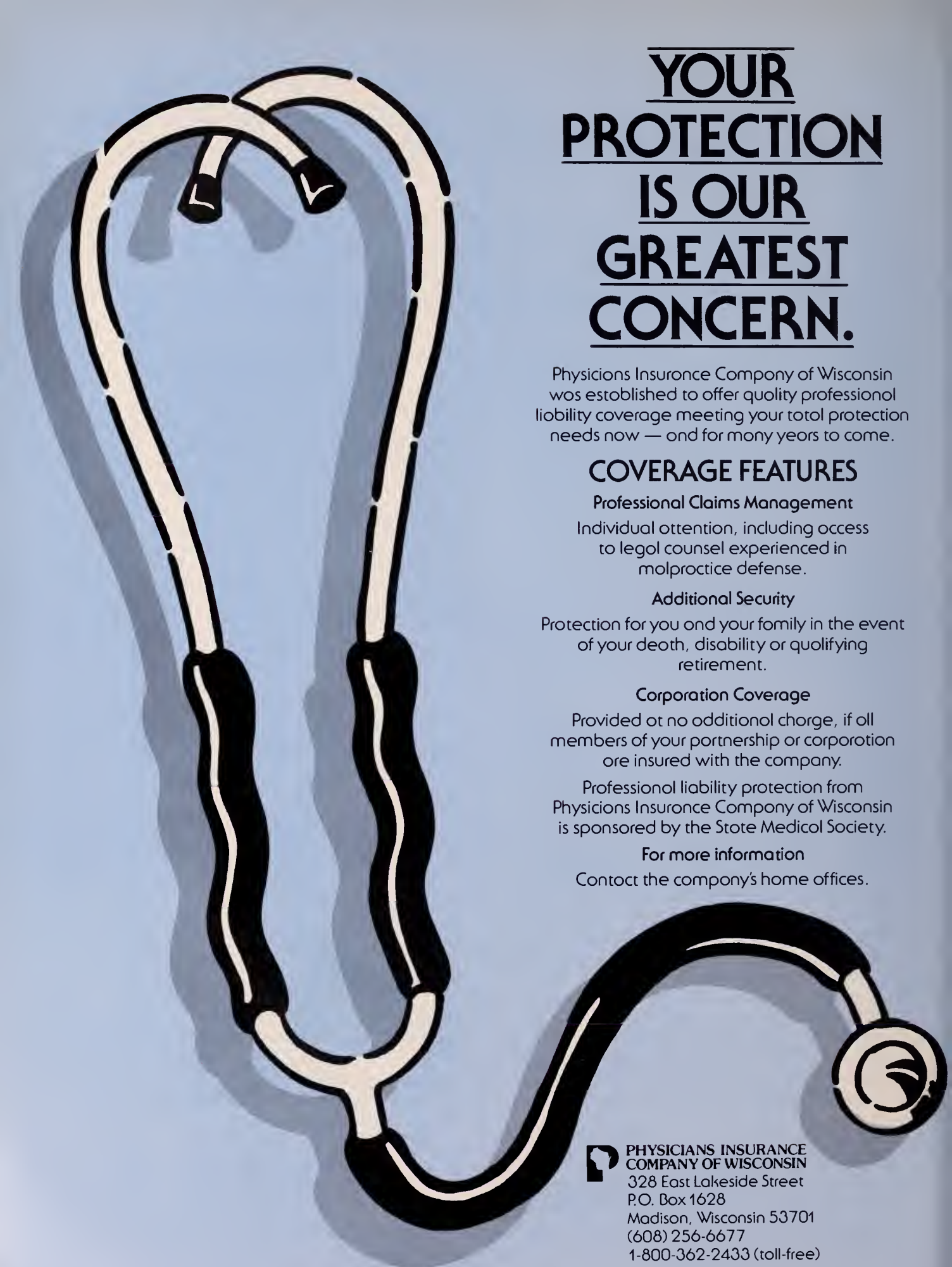

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Continued from page 33

- Engaged in a spirited debate on the merits of the AMA's proposal regarding registered care technologists (RCTs);
- Approved the nominations of 31 members to the WISPAC Board of Directors;
- Approved a recommendation by the Task Force on Physician Review and Discipline that it reevaluate the performance of the Medical Examining Board regarding physician discipline in one year (look for a complete report in the November issue of the *WMJ*); and
- Heard a number of reports from SMS committees, task forces, and staff on various topics including medical liability, peer review issues, and public safety.■

Nominating Committee to meet

The SMS House of Delegates Nominating Committee will again this year meet in conjunction with the Leadership Conference on Saturday, Oct 22, at the Oshkosh Hilton and Convention Center (formerly the Radisson Hotel) in Oshkosh. The committee receives nominations and interviews candidates for the elected positions within the SMS. Following the nomination and interview process, the Nominating Committee assembles a slate of officers to be voted on by the House of Delegates at its 1989 annual meeting (scheduled for April 13–15 in Milwaukee). The committee will seek nominations for the following positions:

- President elect for 1989–90
- Treasurer for 1989–90 to succeed John J. Foley, MD, of Menomonee Falls
- Speaker of the House of Delegates for 1989–91 to succeed Richard G. Roberts, MD, of Madison (completing first two-year term)
- AMA Delegates for calendar years 1990 and 1991 to succeed Richard W. Edwards, MD, of Richland Center, John D. Riesch, MD, of Menomonee Falls, and Timothy T. Flaherty, MD, of Neenah
- AMA Alternate Delegates for calendar years 1990 and 1991 to succeed: J D Kabler, MD, of Madison, Kenneth M. Viste, Jr, MD, of Oshkosh, and Richard H. Ulmer, MD, of Marshfield
- AMA Alternate Delegate for calendar years 1989 and 1990 to succeed Jerome W. Fons, Jr, MD, of Greenfield

All incumbents, except for the current president elect, are eligible to succeed themselves. Nominations may be sent to the Nominating Committee at SMS, PO Box 1109, Madison, WI 53701.■

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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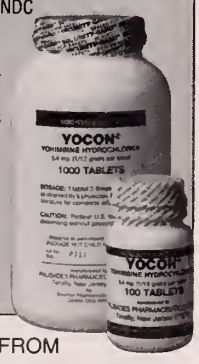
References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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Leadership conference: Oct 22

"Coping with High Rates of Change" is the theme of the SMS 1988 Fall Leadership Conference to be held Saturday, Oct 22, at the Oshkosh Hilton and Convention Center (formerly the Radisson Hotel) in Oshkosh.

The conference will address many of the topics in the forefront in health care including the Harvard Resource-Based Relative Value Scale (RBRVS), registered care technologists, rationing of health care and effective communications. Also included in the program are updates about Society activities on topics as diverse as PartnerCare, AIDS, health care legislation and tort reform.

The conference is free to SMS members, but registration is requested. If you did not receive a registration packet, contact the Communications Division at SMS, 1-800-362-9080 or 608-257-6781.

Plan now to attend what promises to be a most interesting Society conference.■

SMS Chairman appointed to state board

Gov Tommy Thompson, at the urging of the SMS, has appointed Roger L. von Heimburg, MD, of Green Bay, to the Board of Health Care Information. The board will oversee the activities of the Office of Health Care Information, which was created during the 1987 legislative session. Dr von Heimburg is also chairman of the SMS Board of Directors.

The office will later this year begin collecting and analyzing data on the cost, use and quality of health care in the state. Part of the Department of Health and Social Services, it will at first be limited to gathering data on hospital services, but could begin to look at physicians after 1992, according to David Duax, director of the office. The establishment of the Office of Health Care Information was supported by the SMS, the Wisconsin Hospital Association and the Wisconsin Manufacturers and Commerce.

The seven-member board to which Dr. von Heimburg was appointed is charged with determining how the data will be collected and approving any administrative rules promulgated by the office. It will also advise the Office on Health Care Information on various technical issues and policies.■

Roger L. von Heimburg, MD

Physician briefs

Max Smith, MD,* of Madison, recently retired after 35 years of practice. A psychiatrist, Dr Smith was instrumental in establishing the state's first community hospital psychiatric unit at St Mary's Hospital Medical Center in Madison. He also was chief of staff at St Mary's from 1969 to 1972, served on the hospital's board of advisors for six years and was chairman of the psychiatry section, also for six years. Dr Smith was a founder and president of the Wisconsin Psychiatric Association and was an assistant professor at the University of Wisconsin Medical School. He received his medical degree from the UW in 1944.

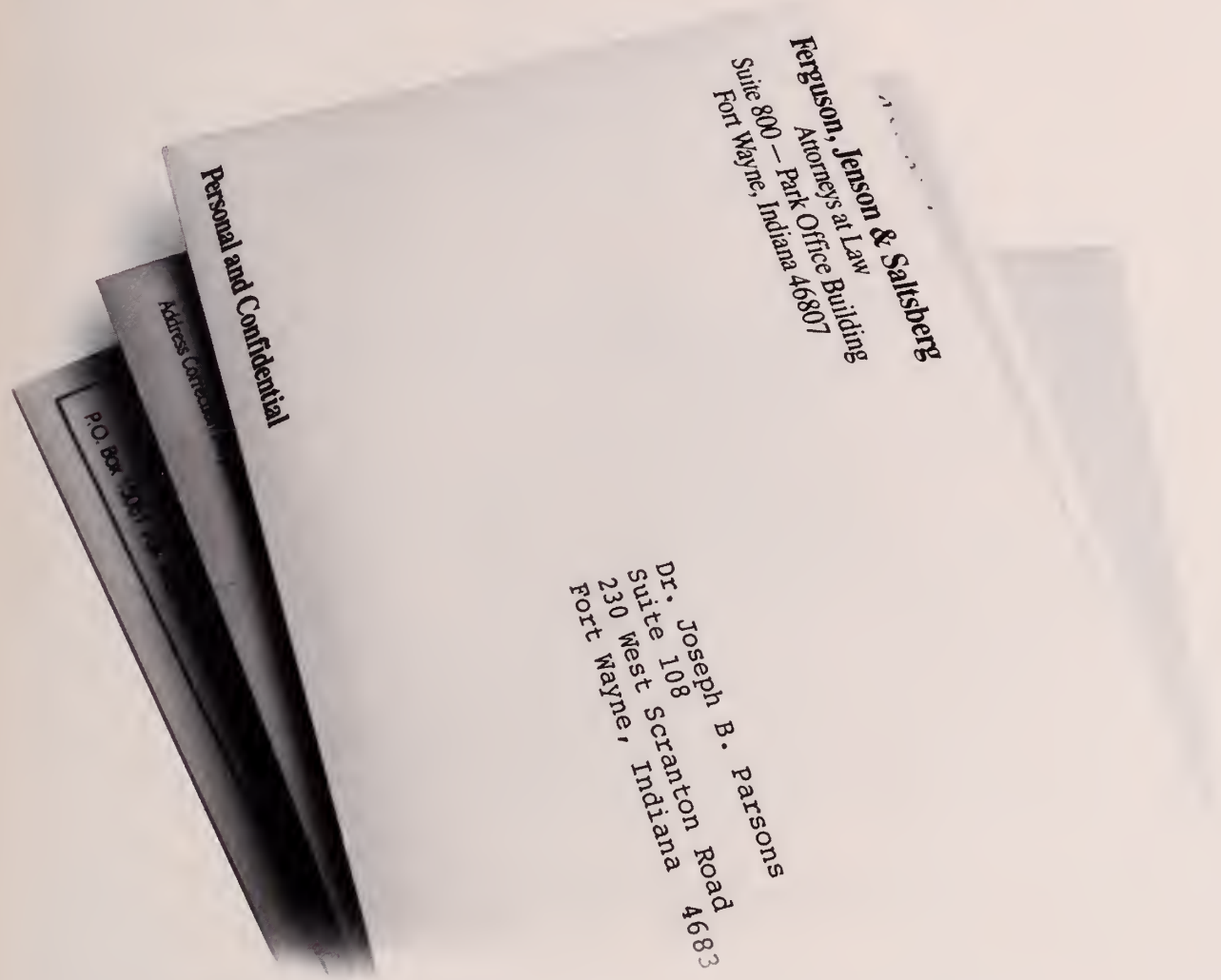
Constantine Panagis, MD,* recently retired as commissioner of health for the City of Milwaukee. He had served in the position since 1973. A board-certified specialist in internal medicine, Dr Panagis received his medical degree from Marquette University School of Medicine in Milwaukee and served a residency at Milwaukee County General Hospital.

James D. Schumaker, MD, has joined the Marshfield Clinic–Colby Center as a family practice specialist. A native of Two Rivers, Dr Schumaker received his medical degree from the University of Wisconsin Medical School in Madison and completed a residency at the University of California–Davis and Scenic General Hospital in Modesto, Calif. He was previously with a small group practice in Kezar Falls, Minn.

Thomas L. Schlenker, MD,* of Milwaukee, has been appointed special deputy in charge of medical services for the City of Milwaukee's Health Department. A pediatrician, Dr Schlenker graduated from Northwestern University Medical School and has served as a clinical instructor at the Medical College of Wisconsin in Milwaukee and also as director of

Continued on page 38

Crisis in black and white.



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Continued from page 36

pediatrics at San Carlos Hospital in Chiapas, Mexico. He recently received a masters degree in public health from Harvard University.

Terrence P. Hughes, DO, of Sussex, recently was named president of the Wisconsin Association of Osteopathic Physicians and Surgeons at the group's annual meeting in Milwaukee.

Marylyn Sutton Ranta, MD,* recently joined Forest View Pediatrics in Hales Corners. Dr Ranta received her medical degree from the University of Indiana and served a residency in pediatrics at the University of Minnesota.

Adolf L. Gundersen, MD,* of La Crosse, was recently appointed by Gov Tommy Thompson to the University of Wisconsin System Board of Regents for a seven-year term. The 17-member board oversees the University of Wisconsin system, which comprises 26 campuses. A specialist in general and vascular surgery, Dr Gundersen is chairman of the department of surgery at the Gundersen Clinic and is on the staff at La Crosse Lutheran Hospital. Dr Gundersen graduated from Harvard Medical School.

Dale E. Rozeboom, MD,* has joined the staff of Riverview Clinics, Ltd, in Edgerton. A specialist in obstetrics and gynecology, Dr Rozeboom graduated from the University of Iowa College of Medicine. He served a residency at the University of Iowa Hospitals in Iowa City.

Karin Krygsman, MD,* recently joined the Hartland Clinic medical staff. Dr Krygsman, a family practice specialist, received her medical degree from the Medical College of Wisconsin and completed a residency at Waukesha Memorial Hospital.

Warren E. Frick, MD,* has joined Riverview Clinics, Ltd, in Janesville. Dr Frick served an internship and residency at the University of Missouri–Columbia. He is an allergist.

Harold B. Garner, MD,* has joined the medical staff of the Artwich Clinic, Ltd, of Oconto Falls. A specialist in internal medicine, Dr Garner graduated from the University of Kentucky College of Medicine and completed a residency at the Marshfield Clinic.

Richard Romeis, MD, recently became affiliated with Eagle River Memorial Hospital and the Kalmar Clinic. Board certified in internal medicine, Dr Romeis graduated from the University of Wisconsin Medical School and completed a residency at St Joseph's Hospital in Marshfield.

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MANAGING EDITOR: Ron Henrichs, 330 East Lakeside Street, Madison, Wisconsin
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Total distribution	7322	7230
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I certify that the statements made by me are correct and complete.

/s/RON HENRICHS
Managing Editor

Date of filing: Sept 12, 1988
PS Form 3526, modified above for purposes of printing

David E. Coleman, MD,* has joined the Nicolet Clinic of Oshkosh. Dr Coleman, who is a board-certified family practice specialist, received his degree from Creighton University School of Medicine in Omaha, Neb, and served a residency at the Medical College of Wisconsin.

Sean P. Alwin, MD,* recently joined the Medford Clinic medical staff. Dr Alwin graduated from the University of Wisconsin Medical School in Madison and served an internship at the Marshfield Clinic. He is a general practitioner.

Joseph W. Pavelsek, MD,* of Portage, recently retired after 37 years of practice as an internal medicine specialist. Dr Pavelsek graduated from the University of Wisconsin Medical School and served an internship at Leila Y. Post Montgomery Hospital in Battle Creek, Mich. He was chief of staff at Divine Savior Hospital in Portage from 1983 to 1985.

Bruce R. Abrams, MD,* a specialist in obstetrics and gynecology, recently joined Nicolet Clinic in Oshkosh. He received his degree from the University of Wisconsin Medical School and completed a residency at Southern Illinois University School of Medicine in Springfield.

Clair M. Morud, MD,* and **Dennis L. Zahm, MD,*** recently joined Medical Associates North in Ashland. Both are specialists in internal medicine. Dr Morud graduated from the St Louis University School of Medicine and served a residency at the University of Nebraska Medical Center in Omaha. Dr Zahm received his medical degree from the Michigan State University College of Human Medicine in East Lansing. He completed a residency at McLaren General Hospital, Michigan State University, in Flint.

Steven J. Pizer, MD,* has joined the Sheboygan Clinic. Dr Pizer graduated from the University of Wisconsin Medical School and completed a residency in pediatrics at the Michigan State University and affiliated hospitals.

Bardomiano Sanchez, Jr, has joined the Marshfield Clinic–Chippewa Falls Center. An internist, Dr Sanchez received his medical degree from the Brown University Program in Medicine in Providence, RI, and completed a residency at Brown and Miriam Hospital.

John L. Melvin, MD,* of Milwaukee, was recently installed as president of the American Congress of Rehabilitation Medicine. Dr Melvin is medical director of Curative Rehabilitation Center in Milwaukee.

Mark H. Andrew, MD,* of Viroqua, was recently appointed to serve on the hospital emergency care capability categorization advisory committee (ConCatCom) by John Torphy, administrator of the Wisconsin Division of Health. Dr Andrew graduated from the University of Wisconsin Medical School and served a residency at Southwestern Michigan Area Health Education Center in Kalamazoo, Mich.

Joy A. Rynda, MD,* and **Waheeda F. Sajjad, MD,*** both pediatricians, recently joined Park Crest Medical Clinic in New Berlin. Dr Rynda received her medical degree from the Medical College of Wisconsin and served a residency at Children's Hospital of Wisconsin in Milwaukee. Dr Sajjad graduated from Gandhi Medical College in Hyderabad, India, and served a residency at Columbus Hospital in Chicago.

Mark D. Osterloh, MD, recently opened a medical practice in Green Bay. An ophthalmologist, Dr Osterloh received his medical degree from the University of Arizona and completed a residency at Mount Sinai Medical Center in Cleveland.

Richard Jennings, DO, recently became a member of the Beaver Dam Community Hospitals medical staff. Dr Jennings graduated from the Chicago College of Osteopathic Medicine and served internships at Mount Clemens General Hospital in Michigan and the Geisinger Medical Center in Danville, Penn. He served a residency at the Geisinger Medical Center.

St Agnes Hospital of Fond du Lac recently announced that four physicians have joined the hospital's medical staff. They are Alan Roetker, MD, Suzanne Vincent, MD, Felix Chu, MD, and Edward J. Chesna, MD.* Dr Roetker received his medical degree from the University of Iowa and completed a residency at the Medical College of Wisconsin. He is an orthopedic surgeon. Dr Vincent, a pediatrician, graduated from the Caribbean School of Medicine in the West Indies and completed a residency at Children's Hospital of Wisconsin in Milwaukee. An otolaryngologist, Dr Chu received his medical degree from St Louis University and completed a residency at the University of California, San Francisco. Dr Chesna graduated from Loyola Stritch Medical School in Maywood, Ill, and served a residency at McGraw Hospitals, Loyola University.■

Radiation impairs sense of smell

Radiation used to treat head and neck cancer can seriously impair a patient's sense of smell, according to a study in a recent issue of *Archives of Otolaryngology-Head and Neck Surgery*. The study, done at Kaplan Hospital in Rehovot, Israel, tested the olfactory acuity of 12 patients who were treated with radiation for nasopharyngeal carcinoma or pituitary adenoma. While most patients recovered their sense of smell to some degree three to six months after treatment ended, the study found, none show full recovery.■

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The persons and organizations named below made contributions to the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin during the month of July 1988. The Foundation and the Society salute their generosity.

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Membership update

The following information is being provided from membership reports and from individual members for updating the 1988 Membership Directory as published in the August 1988 issue of the *Wisconsin Medical Journal*. Because of space limitations, address changes and phone numbers will not be included in this update, although they will be changed in the SMS membership records.

County transfers will be included when processing has been completed by the membership records staff.

Changes in practice specialties (as used by the AMA) and changes in board-certified specialties as listed by the American Board of Specialties (see August 1988 Membership Directory) are included. Practice specialties appear before the slash (/) and board-certified specialties appear after the slash.

Adrouny MD, Salpi
6901 West Edgerton
Milwaukee, WI 53220

Alt MD, Robert L.
1912 Atwood Drive
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J5/230 CSC
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AN

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Barr MD, Craig D.
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Sturgeon Bay, WI 54235

Battista MD, Joseph C.
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GS

Baugrud MD, Kathleen Ann
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OPH OS

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Boblin MD, James D.
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Wauwatosa, WI 53225
N

Bohn MD, Michael J.
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Madison, WI 53703
P

Bosch MD, Nicholas C.
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Wausau, WI 54401
TS/TS

Bottcher MD, Michael L.
1435 S 84th St
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U

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Eligibility: Contestants must either be students enrolled in a Wisconsin medical school or residents practicing in Wisconsin.

Deadline: Papers must be received by the *WMJ* by Jan. 1, 1989: PO Box 1109, Madison, WI 53701.

Rules: Papers must be typewritten, double-spaced with 1-inch margins, and no longer than 10 pages. Topics must fall within the parameters of scientific medicine. The *WMJ* editorial board serves as the panel of judges and has final authority.

Criteria: scientific merit, applicability, content, innovation and writing ability.

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Zell MD, Antoinette Marie
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EM

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Oregon, WI 53575

(From Trempealeau-Jackson-Buffalo to Polk)
Galewyrick MD, Kenneth Lee
225 Scholl St
Amery, WI 54001

(From Barron-Washburn-Burnett to Dane)
Pochis MD, William T.
1927 West Lawn Ave
Madison, WI 53711

(From Milwaukee to Waukesha)
Richie MD, Michael G.
W180 N7950 Town Hall
Menomonee Falls, WI 53051

(From Milwaukee to Rock)
Wallmeyer MD, Kenneth
1905 Huebbe Parkway
Beloit, WI 53511

(From Wood to Dane)
Wex MD, Thomas E.
1313 Fish Hatchery Road
Madison, WI 53715■

Medicinal plants face extinction

A quarter of the world's medicinal plants face extinction within 60 years, according to experts at a recent conference sponsored by the World Health Organization, the World Wildlife Fund and the International Union for the Conservation of Nature. The experts' predictions were reported in *The New York Times*.

The conference produced the following data: 80% of the world's people rely on medicinal plants; and 25% of prescriptions in the United States are filled by drugs derived from plants, with the percentage rising to 40% for anti-cancer drugs.

Among the 60,000 endangered plants are cinchona (from which quinine is produced), reserpine (some tranquilizers) and varieties of foxglove (digitoxin and acetyldigitoxin).■

Obituaries

Wolfgang O.W. Dietsche, MD, 62, Wisconsin Rapids, died May 17, 1988, in Rochester, Minn. Born May 21, 1915, in Freiburg, Breisgau, Germany, Dr Dietsche graduated from the University of Freiburg, and completed his internship at Freiburg University Hospitals in Germany. After practicing medicine in Great Britain, Dr Dietsche came to the United States in 1956 and served an internship at New Rochelle Hospital, NY, and an orthopedic residency at Mount Carmel Hospital and Children's Hospital, Columbus, Ohio. Dr Dietsche came to Wisconsin Rapids in 1967 and founded the Orthopaedic Surgery Clinic of Wisconsin Rapids, SC, retiring in 1986. He was a fellow of the American College of Surgeons and of the American Academy of Orthopaedic Surgeons. He was a member of the Wood County Medical Society, the SMS, and the AMA. Surviving are his widow, Ilse; a son, Thomas, of Bloomington, Minn, and a daughter, Christine of Minneapolis, Minn.

Regalado A. Tendero, MD, 66, La Crescent, Minn, died July 11, 1988, in La Crosse. Born May 13, 1922, in Asingan Paugasinan, the Philippines, Dr Tendero graduated from the University of Santo Tomas College of Medicine in Manila. Dr Tendero came to the United States in 1955 and completed residencies at Mercy Hospital, Cedar Rapids, Iowa, and Allegheny General Hospital in Pittsburgh, Penn. He was a member of the medical staff of St Francis Medical Center, La Crosse, and was the director of the Department of Anesthesiology until his retirement in 1987. Surviving are his widow, Ingeborg; four daughters, Clarissa, of Sacramento, Calif; Evelina Punongbayan, of the Philippines; Cora Mabesa, of San Diego, Calif; Hayda Kraemer, of West Berlin, Germany; and two sons, Arnulfo, of the Philippines, and Armando of Los Angeles.

Paul J. Lawrence, MD, 83, West Palm Beach, Fla, died June 10, 1988, in West Palm Beach, Fla. Born June 3, 1905, in Burlington Vt, Dr Lawrence graduated from the University of Vermont Medical School, and completed an internship at Fanny Allen Hospital in Burlington, Vt. He was assistant medical director of Lakeview Sanitarium in Madison, and held positions as assistant medical director at Southern Wisconsin Colony, Union Grove, and as medical director of Kenosha County institutions in Kenosha, and Rock County institutions in Janesville. Surviving are his widow, Jewell Ferril Volkoff, of West Palm Beach; two sons, Dr Donald Lawrence of Carbondale, Ill; Tom, of Racine; three daughters, June Ripp, of Madison; Kathleen Ehlen, of Union Grove; and Jeannine Muhl of La Luz, New Mexico.

Randolph William Kreul, MD, 83, former Racine physician, died May 26, 1988, in Cape Coral, Fla. Born in Racine on Sept 24, 1904, Dr Kreul graduated from St Louis University Medical School in 1930, and served his internship at Milwaukee County General Hospital. Dr Kreul practiced medicine in Racine from 1931–1985. He served on the medical staffs at St Luke's and St Mary's hospitals and was a past president of St Mary's medical staff. Dr Kreul served in the US Navy during World War II, in the South Pacific, with a rank of commander. He was a member and past president of Racine County Medical Society, a member of the SMS, and the AMA. He also was a member of the SMS Fifty Year Club. Surviving are his three sons, Randolph W. (Mary), of Fond du Lac; Richard J. (Mary Ann), of Racine, and Dr John R. (Joan) of Madison.

Thayer C. Davis, MD, 70, Beaver Dam, died June 16, 1988, in Beaver Dam. Born Oct 12, 1917, in Warroad, Minn, Dr Davis graduated from Marquette University School of Medicine, Milwaukee, and served his internship and residency at Milwaukee County General Hospital. Dr Davis retired from his ophthalmology practice in 1983. He was a member of the Dodge County Medical Society, the SMS and the AMA. Surviving are two sons, Thayer, of Tomahawk; George Davis, MD, of Beaver Dam; and a daughter, Lucinda Scholten, MD, of Ames, Iowa.

Isidore A. Davidoff, MD, 89, Los Angeles, Calif, died July 6, 1988, in Los Angeles. Born Nov 14, 1898, in Milwaukee, Dr Davidoff graduated from Washington University Medical School and served his internship at Mt Sinai Hospital in Milwaukee. Dr Davidoff had practiced medicine in Milwaukee since 1924 and had served as chief-of-staff at Mt Sinai Hospital. He was a member of the American Academy of Family Physicians, the Medical Society of Milwaukee County, the SMS, and the AMA. Surviving are two daughters, Barbara Bremmer and Renee Davidoff, of Los Angeles; and a granddaughter, Dr Donna Davidoff of Mequon.

William M. FitzGerald, MD, 76, Beloit, died July 15, 1988, in Beloit. Born Nov 3, 1911, in Beloit, Dr FitzGerald graduated from Northwestern Medical School, Evanston, Ill, and served his internship and residency at St Louis City Hospital in Missouri. He was one of the cofounders of the Beloit Clinic in 1947. Surviving are four daughters, Margaret Pokorny, of West Springs, Ill; Patricia Rasmussen, of St Paul, Minn; May Katharine FitzGerald-Fleck, of Elkhorn; Alendria Kealey, of Long Valley, NJ; three sons, Dr William, of Beloit; Thomas, of Minneapolis, Minn, and James, of Chicago, Ill. ■

Physicians Exchange

Family Practitioner. Family practice physician wanted to be associated with branch clinic of a large multispecialty group. Opportunity for family practice in Prairie du Chien, Whitehall, Viroqua or Tomah, Wisconsin; West Union, Iowa. Physician would be associated with a multispecialty group. Relief provided for vacations, meetings, etc. Educational opportunities through an excellent education program. Beautiful countryside, cultural and recreational facilities. Excellent fringe benefits. Salary commensurate with background and experience. Write or call: Tim Skinner, MSEd, Family Practice Representative, Gundersen Clinic, Ltd, 1836 South Ave, La Crosse, WI 54601. Equal Opportunity Employer. 10/88

Family Practitioner needed by progressive and stable HMO in west central Wisconsin city of 50,000. Highly competitive salary with excellent fringe. Practice high quality care in a good recreational area. Send CV to Robert Braastad, MD, 1030 Regis Court, Eau Claire, WI 54701. p10–12/88

Anesthesiology, Dermatology, Family Medicine, General Surgery, Internal Medicine, Orthopedics, Otolaryngology, OB/GYN, Pediatrics, Psychiatry. ALRMG is a 37-MD non-HMO clinic in beautiful Albert Lea, Minn. These positions are created by retirements and development of new departments. The hospital and clinic are modern, progressive, established and the primary health care providers in our service area. Excellent educational and cultural opportunities. Competitive income, excellent benefits, early shareholder status with first year salary guarantee with incentive options. Send CV to Administrator, ALRMG, 1602 Fountain St, Albert Lea, MN 56007-1642 or call 507-373-8251 for further information. p8–10/88

RATES: 50¢ per word, with a minimum charge of $20.00 per ad. BOXED AD RATES: $25.00 per column inch. *All ads must be prepaid.*

DEADLINE: Copy must be received by the 1st of the month preceding month of issue; *eg,* copy for the August issue is due July 1. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free in Wisconsin: 1-800-362-9080.

Psychiatrist/Chemical Dependency. Psychiatrist interested in chemical dependency needed to join 220-physician multispecialty group with adjacent 447-bed hospital. Position includes inpatient services for Chemical Dependency Unit with full range of outpatient chemical dependency services available; Evaluation and Detoxification Unit; outpatient chemical dependency clientele and follow-up; general psychiatric practice also available. Behavioral Medicine Department is presently staffed by seven psychiatrists, one child/adolescent psychiatrist and two psychologists. New clinic building recently completed. Gundersen Clinic, Ltd, is located in La Crosse, Wisconsin, a progressive community of 50,000 built along the shores of the Mississippi River amid scenic bluffs, the city offers excellent recreational facilities. Numerous educational and cultural opportunities are provided by an expanding university with undergraduate and graduate degree programs, and a private liberal arts college. Excellent pension program, no investment required. Service organization. Write: Philip J. Dahlberg, MD, Chairman, Personnel Committee, Gundersen Clinic, Ltd, 1836 South Ave, La Crosse, WI 54601. An Equal Opportunity Employer. 10/88

Independent practice opportunity, Eau Claire, Wis. Extremely busy Board-certified solo family practitioner seeks one to two FP associates. Practice located in newly 1987 constructed 11,000 square foot professional building which also houses a plastic surgeon, podiatrist, and pharmacy. Due to the size of the practice, an outstanding initial employment and compensation package is being offered as well as very attractive associate terms for full partnership after one year. Contact Donald Stewart at 414-731-3004 for additional information. 10–12/88

Eastern Iowa. Progressive young BC FP seeks residency trained BC FP for growing practice. Call every fourth night. Newly remodeled hospital. Active community 19 miles from Iowa's third largest city. Send CV to S. Hanas, MD, 1118 11th, DeWitt, IA 52742. 10–12/88

General Internist/Endocrinologist, Cardiologist / Rheumatologist, BE, Board-certified to join a 16-man internal medicine department in a dynamic growing multispecialty clinic. Attractive salary with a full range of benefits. Mid-size midwestern community with excellent educational, recreational, social activities. Please send CVs and references to: Ross A. Madden, MD, Medical Director, Medical Associates Clinic, PC, 1000 Langworthy, Dubuque, IA 52001. 8–10/88

Pediatrics. Marshfield Clinic, a 270-physician, multispecialty private group practice, is seeking a Board-certified or eligible general pediatrician to join its expanding regional center in Chippewa Falls. Chippewa Falls is a community of 15,000 people located in beautiful west central Wisconsin with a wide range of recreational, educational, and cultural opportunities easily accessible. The clinic is adjacent to a 110-bed JCAH accredited hospital. Competitive salary and fringe benefit package. Send curriculum vitae and references to: Mr David Draves, Director, Regional Development, Marshfield Clinic, 1000 North Oak Ave, Marshsfield, WI 54449 or you may call collect at 715-387-5376. 10/88

Internal Medicine. Board-certified or eligible to join five general internists in a multispecialty group in northeastern Wisconsin. Office is next to two hospitals. Partnership is available after one year. Send CV to Dept 613 in care of the Journal. p10–12/88;1–3/89

Emergency Medicine Careers. National Emergency Services would like to offer you the opportunity for an exciting, challenging career in emergency medicine. Full-time and part-time positions are available throughout Wisconsin. We offer paid malpractice insurance; independent contractor tax status; 2 hour answering service in case of an emergency. Call us today at 1-800-537-3355. 10/88

The Wausau Medical Center is seeking BC/BE individuals in the following specialties: Cardiology, Dermatology, Family Practice, Infectious Disease, Obstetrics/Gynecology, Pediatrics and Rheumatology. Modern clinic facility located across the street from modern 300-bed hospital. Full partnership in three years. Easy access to lakes, woods and mountains. Write including CV to D.K. Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, WI 54401. p4tfn/88

Family practice. Thirty-four physician multispecialty group conveniently located between Chicago and Milwaukee. Well-equipped clinic offering salary guarantee with incentive bonus; excellent fringe benefits and early ownership. Please send current curriculum vitae to Roger D. Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 4tfn/88

Physicians needed full- or part-time to perform light physicals. Milwaukee area. Professional liability provided. Phone 414/344-2100, Ms Jenkins. 10tfn/84

Physicians Exchange

continued

Internist BE/BC. North Shore Internal Medicine, PC, is seeking an energetic general internist to enjoy the benefits of a rapidly expanding practice. New office close to hospital. Michigan State Medical School Campus. Send resume to 2420 First Ave, South, Escanaba, MI 49829; ph 906-786-1563. 10tfn/88

Seeking Emergency Department Director and full-time physicians for 100-bed hospital 35 miles north of Milwaukee. Excellent compensation, malpractice insurance provided and benefit package provided. Contact: Emergency Consultants, Inc, 2240 S Airport Rd, Room 36, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496. p10/88

Internal Medicine. Doctors Clinic, Two Rivers, Wisconsin. Eight-physician group seeks second internist, critical care interest beneficial, three area hospitals. Contact Dept 621 in care of the Journal. p8–10/88

Invasive Cardiologist. Monroe Clinic near Madison, 54-physician group seeks third cardiologist. 270-bed hospital, new cath lab, attractive salary, benefits. Contact Dept 620 in care of the Journal. p8–10/88

RURAL WISCONSIN HOSPITAL COOPERATIVE

Emergency Room Physicians

The Rural Wisconsin Hospital Cooperative (RWHC) is a nationally recognized and award winning organization that provides advocacy and shared services for its 20 member hospitals. We are seeking ACLS certified physicians with Family Practice, Internal Medicine or ER backgrounds and strong communication skills to provide coverage for our participating hospitals. The hospitals served by RWHC are within a two-hour drive from Madison, Wisconsin. Many have ACLS trained nursing staffs and modern emergency room facilities. This network offers flexibility in scheduling, with needs ranging from part to full-time coverage. A competitive salary and access to a variety of benefit options is available.

Contact: Patricia Ruff, Associate Director, RWHC, 404 Phillips Blvd, Sauk City, WI 53583; 608-643-2343. 9/88

Internist with or without subspecialty interests. Board-certified or eligible to join a well-established nine man expanding multispecialty group. Location is in a southeastern Wisconsin city of 36,000 with access to a large inland lake, initial salary plus percentage as an associate. Full status in-service corporation with shared overhead and an incentive orientated formula after the first year. Please contact E.T. Ayala, MD, Department of Internal Medicine, Sharpe Clinic, SC, 92 East Division St, Fond du Lac, WI 54935; ph (414) 921-0560, collect. p6–11/88

West Bend, Wisconsin, General Clinic, a 20-physician multispecialty group is seeking additional B/C, B/E physicians in **Family Practice, Pediatrics, OB/GYN, Internal Medicine, Urology, Dermatology,** and **ENT.** First-year salary and benefits guaranteed. Corporate association after one year. Located in a family-oriented, economically strong small city surrounded by four-season recreational and scenic Kettle Moraine area 30 miles north of metropolitan Milwaukee. Contact Hans W. Schmelzling, Administrator, 279 S 17th Ave, West Bend, WI 53095; ph 414/338-1123. 7tfn/87

Due to retirement, we are seeking a third general surgeon for the surgical department of a 55-member multispecialty clinic in Janesville, Wisconsin. The clinic is on the grounds of a modern and well-equipped hospital with three outlying primary care satellites in neighboring communities. Janesville, Wisconsin, is a city of 51,000 people centrally located between Madison and Milwaukee, Wisconsin, and Chicago, Illinois. Vascular experience is necessary. Excellent benefits are provided. Salary for the first year and then full partnership. If interested, send curriculum vitae to Ronald P. Karzel, MD, Janesville Riverview Clinic, 580 N Washington St, Janesville, WI 53545. 8–10/88

General and Vascular Surgeon, university trained, sought as ambitious associate for very busy surgeon. Rewarding, hard work in sophisticated medical community. Robert Mikkelsen, MD, FACS, 14 N Main St, Fond du Lac, WI 54935. p8;9–11tfn/88

NEW PHYSICIANS FOR WISCONSIN

is seeking

- Family Physicians
- Pediatricians
- Orthopedic Surgeons
- Internists

Contact: Fred Moskol
UW Office of Rural Health
810 University Bay Drive
Madison, WI 53705
608/263-7933
7–12/88;1–6/89

Green Bay. Seeking full-time and part-time physicians for busy emergency department. Outstanding compensation and full malpractice insurance coverage. Benefit package available to full-time staff. Contact: Emergency Consultants, Inc, 2240 S Airport Rd, Room 36, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496. p10/88

Wisconsin. Emergency Medicine opportunities are currently available at various client hospitals in Wisconsin for directorship and staff position. Providing malpractice insurance, Wisconsin Compensation Fund, CME allowance, relocation assistance, and compensation of $90,000 annually. Directorship positions include health benefits and a monthly administrative stipend. $500 paid for qualified referral. For complete details, contact Mary Dwyer, Spectrum Emergency Care, PO Box 27352, St Louis, MO 63141; ph 1-800-325-3982, ext 3031. 10/88

General Surgeon and **Family Practice** opportunities in a group setting. Located in a family-oriented economically strong small city. Located near lakes and metro area of Green Bay and Appleton, Wis. Send CV to Andrew Lagatta, President, Clintonville Community Hospital, 35 N Anne St, Clintonville, WI 54929. 6–10/88

Rheumatologist—the Racine Medical Clinic, a 34-physician multispecialty group conveniently located between Chicago and Milwaukee. Well equipped clinic offering salary guarantee with incentive bonus; excellent fringe benefits and early ownership. Please send curriculum vitae to: R.D. Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 11tfn/87

Career opportunity for qualified Emergency Room physician. Our group covers two hospital emergency rooms and an active walk-in clinic in southeastern Wisconsin. Full fringe benefit package and flexible scheduling offered. Interested parties contact John W. Linstroth, MD, 1201 Sherwood Lane, Caledonia, WI 53108; ph 414-835-7761. 8tfn/88

Emergency Medicine, Otolaryngologist, Urologist, and Obstetrician/Gynecologist to join multispecialty group practice in Woodruff, WI. Guaranteed annual income and excellent fringe benefit program. Send CV to R.J. Sloan, MD, Lakeland Medical Associates, Ltd, PO Box 549, Woodruff, WI 54568. 4tfn/88

Physicians Exchange

continued

BC/BE General Internist to join 26-MD multispecialty group with four internists, one nephrologist and one gastroenterologist. Top salary first year, full incentive thereafter. Central Wisconsin university town with drawing area of 80,000. Send CV to Dr John Gauder, Rice Clinic, SC, 2501 Main St, Stevens Point, WI 54481, or call collect 715/344-4120. 12tfn/87

Twenty-nine physician multispecialty clinic located in desirable East Central Wisconsin location is seeking Board-certified or Board-qualified orthopedic surgeon to round out its services. Lab, x-ray, excellent hospital. Liberal guarantee and benefits. If interested contact D.F. Sweet, MD, Fond du Lac Clinic, SC, 80 Sheboygan St, Fond du Lac, WI 54935. 9tfn/87

Five-member Cardiology Group seeking BE/BC associate with invasive/noninvasive capabilities. Medical referral center for northeastern and east central Wisconsin. Liberal guarantee/benefit arrangements. Full partnership available. Send CV or call: Dr James Cole, Appleton Cardiology Associates SC, 820 East Grant St, Appleton, WI 54911; 414-731-8900. p8–10/88

Medical Consulting Opportunities. The Bureau of Social Security Disability occasionally has openings for part-time consultants who provide medical evaluation on disability claims. Twenty to thirty-five hours per week on hourly compensation. No fringe benefits. Flexible schedule and an East/Central Madison office location. Current opening is for a neurologist. Interested physicians in other fields may submit resumes for consideration of other openings in the future. Contact Dr Fred W. Fletcher, BSSDI, PO Box 7886, Madison, WI 53707-7886; ph 608-266-6608. 9–10/88

Family Practitioner to join a progressive 12-physician practice at its Ellsworth, Wisconsin branch. Rural community 40 miles from St Paul, Minn. Liberal benefit package. Salary commensurate with background and experience. Contact R.M. Hammer, MD, River Falls, WI 54022; ph (715) 425-6701 or (612) 436-8809. 7tfn/88

Family Practice (BC/BE) opportunity to join a five-physician family practice group in south central Wisconsin city of 15,000. Pleasant community atmosphere within 1–1½ hours of Madison and Milwaukee. Excellent recreational area. First year guaranteed salary. Contact: Chad Burchardt, Business Manager, Medical Associates of Beaver Dam, SC, 1200 N Center St, Beaver Dam, WI 53916; ph: (414) 887-7101. p9–11/88

Eagle River—Great opportunity for two BC/BE family practice physicians to join well-established practice. Guaranteed annual income and future partnership available. For more information, send resume to Judy Harris, Recruiter, UW Office of Rural Health, 810 University Bay Dr, Madison, WI 53705 or call collect 608/263-7933. 1tfn/88

Beloit Clinic, SC, an expanding multispecialty group in southern Wisconsin college town is seeking a pulmonologist, radiologist, allergist, ophthalmologist, and orthopaedic surgeon for its main facility, as well as a second family practitioner for a satellite location. Guaranteed salary with incentive plus excellent fringe benefits. Send CV to J. F. Ruethling, Administrator, 1905 Huebbe Parkway, Beloit, WI 53511; ph 608-364-2200. 10–12/88;1–3/89

Miscellaneous

Family Practice. Well-established location, 2557 S Kinnic Ave—Bay View, Milwaukee Wis. Available after December 31, 1988. Inquire Dr James H. Biller, 500 West Bradley Road, Portico—226—C, Milwaukee WI 53217. p10/88

Real Estate

For Rent. Doctor's Office, Hales Corners, Wisconsin, area 1050 sq ft. New building, first floor, ample parking. Reception, business office, three plumbed examining rooms, laboratory, private office and bath. For information call 414-764-6692 or 414-744-8007. 8tfn/88

An Earthly Paradise. Forty acres, wooded. Can be a physician's Shangri-La. In Town of Monches, Washington County. If you are dreaming of building a special home—have the means—we have the most beautiful and desirable place for it. Mrs Ida Lukats, Rte 2, Box 955, Safford, Az 85546; ph 602-428-2881. p10/88

Medical Meetings—Continuing Medical Education

OCTOBER 13–16, 1988: 32nd Annual Meeting of the American Society of Internal Medicine at the Marriott Marquis, Atlanta, GA. Info: call 202-289-1700. g10/88

OCTOBER 20–21, 1988: Wisconsin Chapter, American College of Emergency Physicians, The Abbey, Lake Geneva. 2tfn/88

OCTOBER 28–30, 1988: Wisconsin Psychiatric Association, Landmark Resort, Egg Harbor. g9–10/88

NOVEMBER 4, 1988: *Wisconsin Orthopaedic Society,* Olympia Resort, Oconomowoc. 4tfn/88

NOVEMBER 5, 1988: Wisconsin Allergy Society, InnTowner Hotel, Madison. Info: Robert Bush, MD, 2500 Overlook Terr, Madison, WI 53705; ph (608) 256-1909. gtfn/88

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, clinics, specialty societies, and medical schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 50¢ per word, with a minimum charge of $20.00 per listing. *All listings must be prepaid.*

BOXED LISTINGS: $25.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 1st of the month preceding the month of publication; *eg,* copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free in Wisconsin: 1-800-362-9080.

FOR LISTING of other meetings see the July 1, 1988 issue of the *Journal of the American Medical Association:* Continuing Education Opportunities for Physicians for period August 1988 through December 1988.

Medical Meetings—Continuing Medical Education

continued

DECEMBER 7–9, 1988: Neurology for the Non-Neurologist, The Ambassador West Hotel, Chicago, Ill. Info: Office of Continuing Medical Education, Rush-Presbyterian-St. Luke's Medical Center, 600 S. Paulina, Chicago, IL 60612; ph 312-942-7095. 9–10/88

AMA

DECEMBER 4–7, 1988: Interim House of Delegates, Dallas, TX.

JUNE 18–22, 1989: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 3–6, 1989: Interim House of Delegates, Honolulu, HI.

JUNE 24–28, 1990: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 2–5, 1990: Interim House of Delegates, Orlando, FL.■

State Medical Society of Wisconsin

Dates and locations of
ANNUAL MEETINGS
1989–1993

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel, unless otherwise indicated.

1989—April 13–15
1990—April 26–28: Green Bay Convention Center, Embassy Suites
1991—April 18–20: Milwaukee Wyndham Hotel
1992—April 23–25
1993—April 15–17: La Crosse Convention Center, Radisson

Meetings days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.
Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, WI 53701. Local Telephone: 257-6781; toll-free in Wisconsin: 1-800-362-9080.

NOVEMBER 11–12, 1988: American Diabetes Association/Wisconsin Affiliate, Inc, Post Graduate Course. Topics include: Lipid Management, Retinopathy, Diabetes in Adolescence, Team Management Approach to Diabetes Self-Management. Paper Valley Hotel, Appleton. Info: 414-464-9413. p10/88

1989 CME CRUISE
CONFERENCES ON MEDICO-LEGAL ISSUES AND
RISK MANAGEMENT.
Caribbean, Mexico, Alaska/Canada, China/Orient, Scandinavia/Russia, Mediterranean, Black Sea, Trans Panama Canal. Approved for 24–28 CME Category 1 credits (AMA/PRA) and AAFP prescribed credits. Excellent group rates on finest ships. Prescheduled in compliance with IRS requirements. Information: International Conferences, 189 Lodge Ave, Huntington Station, NY 11746; ph 800-521-0076 or 516-549-0869.
p10–11/88;1/89

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CONTINUING MEDICAL EDUCATION

Sponsored by Marshfield Clinic
Marshfield, Wisconsin

JANUARY 25–27, 1989: *Cancer 89*, Telemark Lodge, Cable

FEBRUARY 4, 1989: *Science Teachers Conference*, Marshfield

FEBRUARY 9–10, 1989: *Winter Pediatric Conference*, Big Powderhorn Ski Resort, Bessmer, Michigan

MARCH 10–11, 1989: *Advanced Cardiac Life Support Course*, Marshfield

Further information or a brochure call the Marshfield Clinic's Office of Medical Education, 1000 North Oak Ave, Marshfield, WI 54449; ph 715-387-5207. 9–12/88

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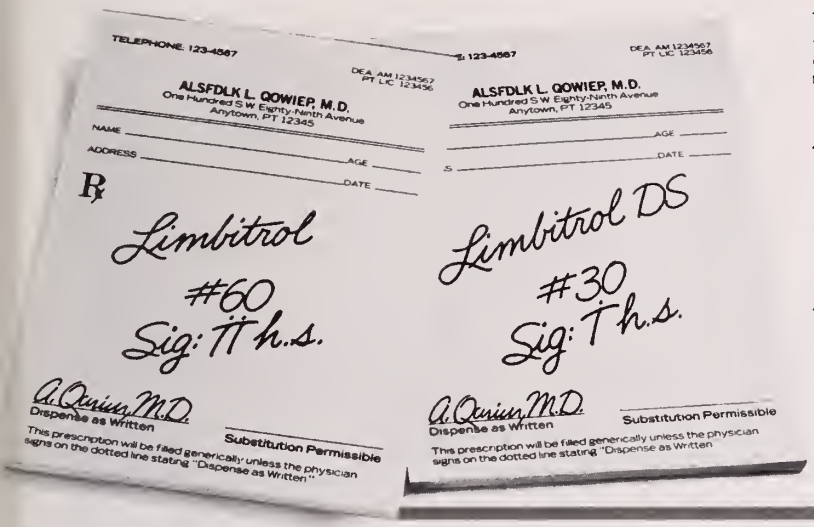

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References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner VP, *et al: Psychopharmacology 61*:217-225, Mar 22, 1979.

Limbitrol®Ⓥ
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Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.**

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. *Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. *Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. *Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. *Endocrine:* Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

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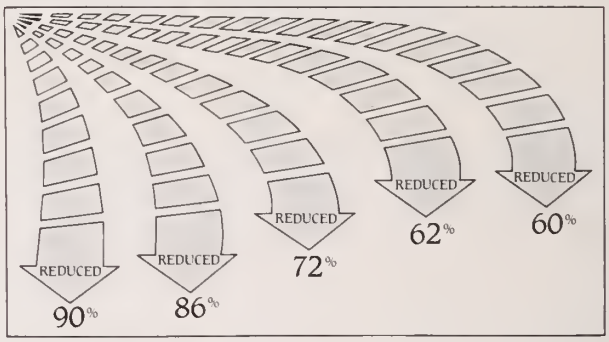

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Wisconsin Medical Journal

V.87 NO.11

Official Publication of the State Medical Society of Wisconsin

Cancer

November 1988

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Wisconsin Medical Journal

The *Wisconsin Medical Journal* (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor and editor are responsible for overseeing the production, business operation and contents of the journal. The editorial board, chaired by the medical editor, solicits and screens all scientific, special and soundings articles. The editorial director provides leadership for the editorial associates and comments on both editorials and letters to the editor. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *WMJ* nor the SMS take responsibility. The *WMJ* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

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State Medical Society of Wisconsin

Created by the Territorial Legislature in 1841 and now representing nearly 7,000 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal*.

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Our cover: "Autopsy" a water color by Aaron Bohrod, given to his brother, Milton Bohrod, MD, a New York pathologist in 1933. Dr Bohrod presented the painting to the SMS Charitable, Educational, and Scientific Foundation in 1969. The painting is on display at the SMS headquarters in Madison.

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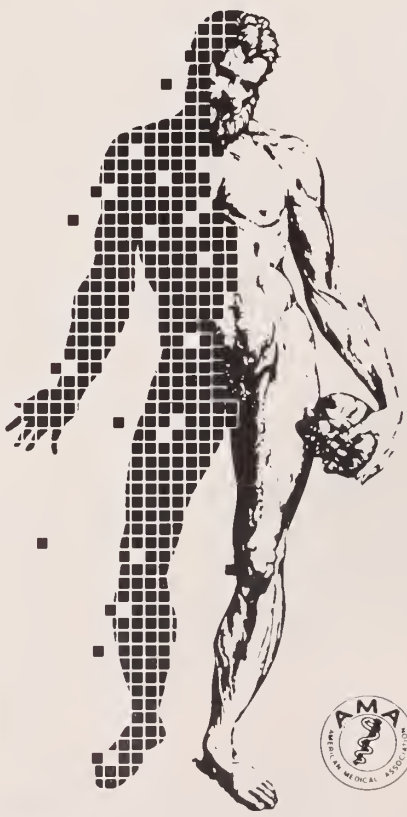

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President's page

Supporting the next generation

MEDICAL SCHOOLS, in common with all other parts of the American medical community, are coping with high rates of change. Tuition and costs are higher; applicants and matriculants are fewer. Students face increasing debt, a rigorous, demanding curriculum and longer postgraduate training. Meanwhile, professional societies and special interest groups urge ever more additions to the already crowded curricula: geriatrics, bioethics, death and dying, medical economics, trauma management, risk management, practice management and stress management are examples. Stress management may be the most germane.

Applications for admission to the nation's medical schools have declined for the past five years and have dropped about 10% per year for the past three years. Some schools, including a public medical school in an adjacent state, have been unable to fill their 1988 entering class with qualified applicants and have reduced class size rather than dilute the quality of their graduates.

Competition among medical schools for the better students and the competition of all medical students with schools of business, engineering and law, for the best and the brightest has become intense. Intelligent and talented students are in a buyer's market and fewer are choosing a profession with the highest tuition, longest training time, and suffering disparaging remarks from some of its own practitioners.

In recent years, the process of filling a medical school entering class has changed from selection to recruitment. Applications from young men are 40% fewer than in 1975. A third of entering medical students now are women (58% of women applicants to US medical schools in 1987 were accepted) and were it not for these well-qualified young women (white and black) aspiring to be physicians, there would be far more empty seats in medical school classrooms. The decade's increasing number of applications from women, however, has leveled off. No school, profession or society can ignore the implications of these trends.

In this contemporary climate of competition, how is Wisconsin and its public medical school at the University of Wisconsin faring? How many Wisconsin residents are going to medical schools? Has the quality of students entering the medical school in Madison declined? Let's look at the data for answers.

Wisconsin ranks 17th in population among the United States. In 1987, enough Wisconsin residents entered a medical school somewhere in the United States to rank Wisconsin 18th in the number of state residents entering medical schools for that year. It does not appear that Wisconsin has suffered a shortage of medical school matriculants—not yet, anyway.

JD Kabler, MD

Nationally, there are 1.7 applicants for each student admitted to medical school. In 1988, the ratio of applicants to those admitted at Madison was more than 2.0. The 143 available positions in the class were filled by well-qualified candidates, 95% of whom were Wisconsin residents. How well qualified? Their average pre-medical gradepoint average (GPA) was 3.55, unchanged from previous classes at Wisconsin and comparing favorably to the average entering GPA of 3.41 among all 126 US medical schools. Moreover, entering Medical College Admission Test scores average between 9 and 10, just as they have in previous years. The data assure us

Continued on page 5.

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Continued from page 3.

that the entering medical school class in September 1988 in Madison was just as qualified as ever, even though chosen from a smaller pool of applicants and facing the fifth highest resident tuition of any public medical school in the nation.

Our current success does not permit complacency. The medical school at Madison must strive to remain competitive, contain costs, actively recruit qualified applicants and foster interest in medical careers among the best and the brightest young adults in Wisconsin. In this endeavor, "gown" needs the support of "town." Physicians everywhere can help by encouraging, not discouraging, promising students—men and women, majority and minority—to enter the same honorable vocation they have chosen.

Pessimism about our profession and its prognosis is inappropriate. Illness and injury are inevitable: somehow, some way, somewhere, we will always be needed.■

Editorial

Turf battles

SPECIALIZATION IN MEDICINE evolved to fill a need as technological advances have forced us to admit that we cannot be all things to all men. Certain areas of the body and organ systems logically have become the domain of the specialist interested in those areas, and the patient is well-served, generally.

But what happens when there is overlap? Is the nose the province of the otolaryngologist when it is plugged, but of the plastic surgeon when it is bent? And what if it's broken? Who gets it then?

Newer procedures bring new conflicts. Where liposuction first appeared a few years ago, the plastic surgeon had it all to himself, but the "area" surgeons soon proclaimed that if the fat lay in their zone, they should perform the liposuction. And the fight was on.

Gastrointestinal endoscopic procedures can be performed very well by gastroenterologists. But the surgeons who have seen their own field become narrower and narrower say, "Enough is enough—we want to do endoscopy, too."

And they do.

The most recent controversy appears to be that between the radiologists and invasive cardiologists over peripheral angioplasties. The vascular surgeons, more accustomed to working with radiologists as angiographers in evaluating peripheral vascular disease, act as referees, and stand by to take care of the failures.

So it goes. Each conflict will probably be decided on a local basis, depending on the comparative strengths of the specialty societies in each region and on local tradition.

The final decision-making power does not reside with the specialty societies, though: It is the responsibility of the hospital credentials committee and the hospital board, for it is they who must assure quality in patient care. There seems to be only one sensible approach anyway—grant the privileges on the basis of the applicant's training and qualifications, but taking into account regional tradition. And although that sort of practice ought to be fair and trouble-free, if a hospital has never in its history permitted family practitioners to repair hernias granting those privileges now might make political sense but will it bring in any referrals of patients with hernias to the family practitioners? Very few, probably, and then the credentials committee will have to ask itself the other question: Can a physician who does only occasional procedures maintain his skills at those procedures?

In the coming years, the chief-of-staff will have his hands full.

—Wayne J. Boulanger, MD
Milwaukee■

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

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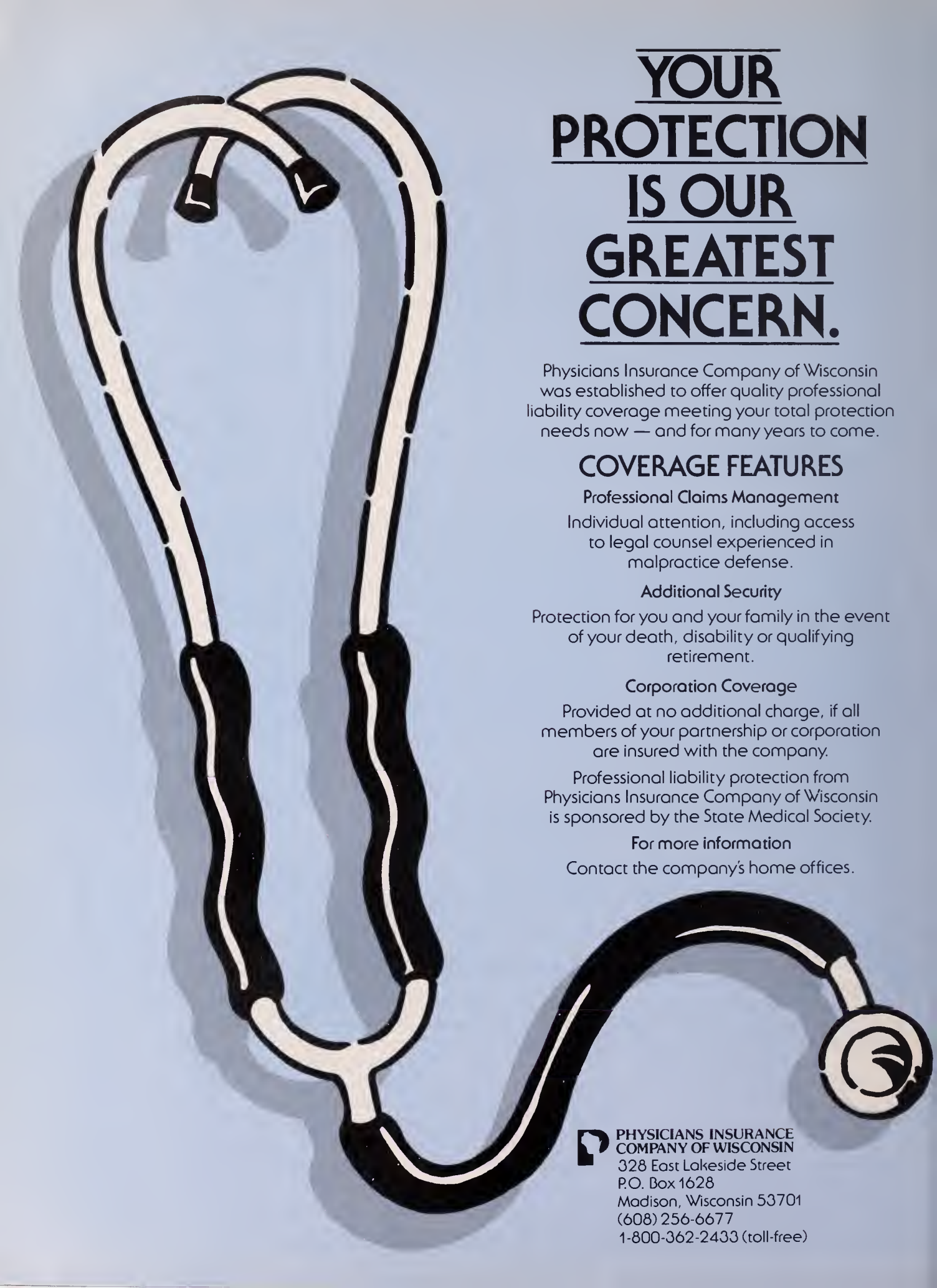

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Secretary's report

Making a legislative investment

AS I WRITE THIS, the November election is just around the corner and election rhetoric, campaign promises and pleas for support fill the airwaves, the newspapers, and much of our incoming mail here at the SMS. Our political action committee, WISPAC, has been hard at work and highly visible in a number of important campaigns, as has our national counterpart AMPAC, actively supporting candidates with solid positions on issues important to the medical profession.

Like most, if not all, political action committees, WISPAC works hard year-round to increase physician and auxiliary member participation in politics, but once every two years it takes center stage when the election cycle comes around again. Dr Tim Flaherty, who is the WISPAC chairman and a member of the AMPAC Board (the first from Wisconsin), Dr Bill Treacy, who was the WISPAC chairman until June of this year, and the physicians and auxiliary members who serve on the WISPAC Board and local interview committees to review candidates for state office, deserve credit for their service to the profession. With their help and yours we are strengthening medicine's role in the political process and, as constituents, holding legislators and candidates accountable.

But what happens after the polls close, after the last ballot is counted, after the victory party decorations have been taken down? From the end of the campaign season until the Legislature returns in January, there is still much that can be done to cement or improve relationships with those people who will be deciding the fate of many issues you care about. This is an ideal time to nurture the seedling of physician support and involvement planted by WISPAC, and to prepare the ground for the next period of cultivation when the Legislature is at work in earnest. Your contacts with your legislator next spring will be more effective if you've already established a relationship with him or her.

The legislative contacts of each and every society and auxiliary member will be needed as we pursue a full agenda of liability reform health care for the uninsured, defeating mandatory assignment, keeping the seat belt law, improving medicaid reimbursement, and the host of other issues we know we must deal with.

Some of the things you can do right now include:

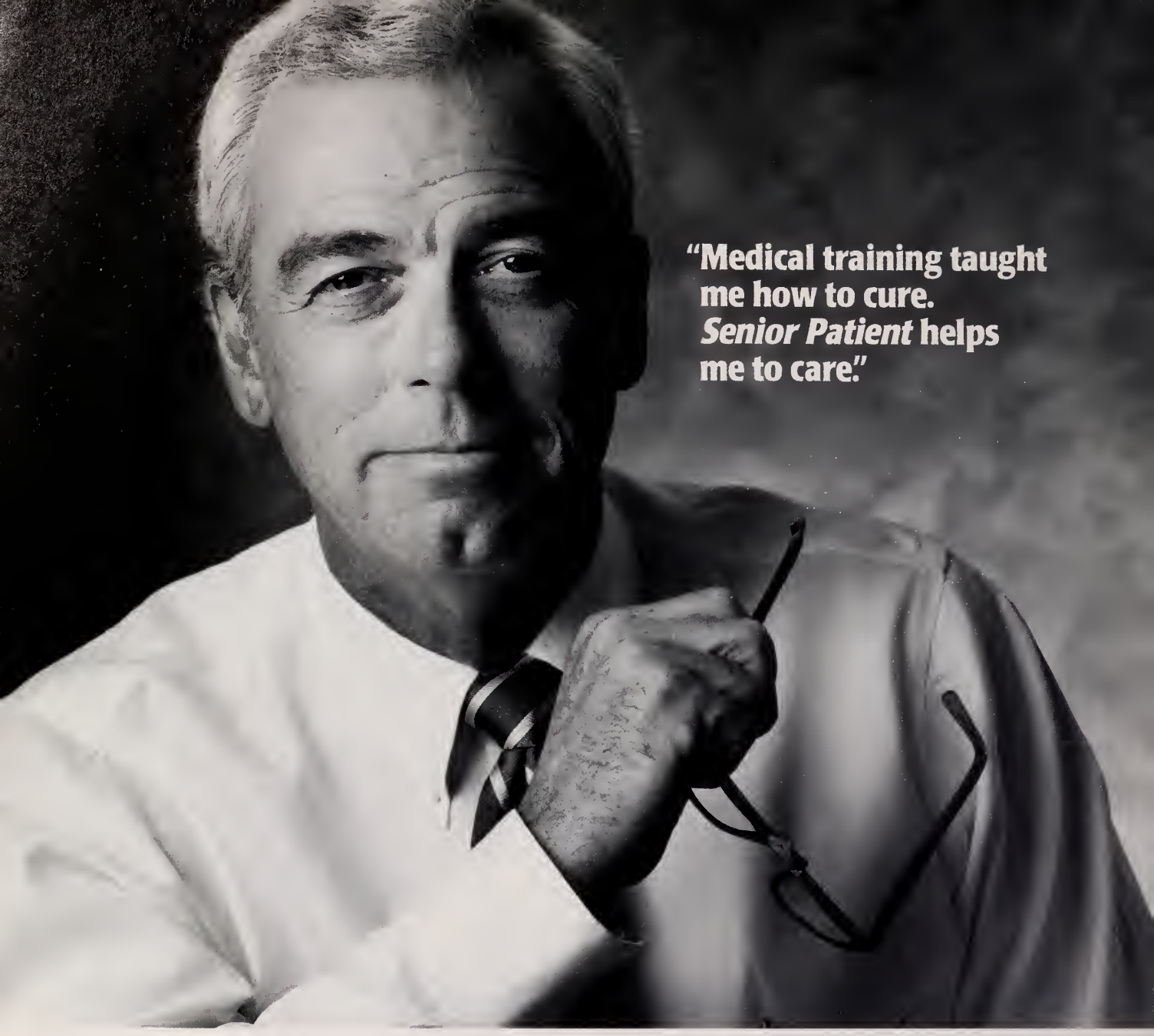
- Write a congratulatory note to your legislators who have just been elected or re-elected. It doesn't need to be long—in fact, short is better—just enough to let them know you noticed and you cared. Most mail legislators receive is asking for something, so it is a rare and appreciated treat to simply receive a positive note.
- If the legislator has a debt from the campaign, make a contribution. If the candidate you supported lost, and you want to try to establish a relationship with the candidate who won, this is a useful starting point.
- Consider meeting with your legislator before the session starts to discuss a few of the health care issues likely to come up. Keep the meeting a congenial discussion and sharing of information on both sides. Alternatively, you may wish to invite the legislator to address a small group rather than bringing him or her in just to listen to your recitation of issues. The SMS Medical Society Relations staff in the Division of Public Affairs is available to assist in setting up meetings with legislators and county medical societies, hospital medical staffs, or clinics.

Thomas L. Adams

- Find out what issues your legislator is interested in. Offer to serve as a resource, or to find others who are willing, for information on medical issues. If a legislator wants more information, try to provide it (the SMS can help), but be careful not to provide so much information that it's overwhelming, and don't try to force a legislator to become a leader on health care issues if his or her chief goal is to reform the state's energy policy.

Most legislators are by necessity generalists, with hundreds of issues brought to their attention each session, and they will not pretend to be an expert on all subjects. Some will be more interested in our issues than others. Don't assume you have to always discuss medical issues; listen to your legislator's comments on the issues that are important to him or her. (A great entree into such a discussion is to ask a legislator what committee appointments he or she would like to have in the upcoming session.)

In politics, as in other human endeavors, the best friendships are those you make before you have a favor to ask.■



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Clinical cancer series closes: A tribute to Ernest C. Borden, MD

OVER THE YEARS, the *Wisconsin Medical Journal* has published a number of scientific papers in series form.

The first of these probably was the Clinical Pathological Conference series, which was published monthly for many years. In the past, clinical pathological conferences were conducted frequently in many hospitals, but today seem to have faded away.

One of the most popular series appearing in the *WMJ* was Therapeutic Dilemmas, edited by Harry Beckman, MD, of Milwaukee. Dr Beckman (famed among *WMJ* readers for his Comments on Treatment page) had served as professor and chairman of Marquette University School of Medicine's Department of Pharmacology for nearly four decades and was a prolific contributor to the *WMJ*. Upon his retirement in 1967 he undertook the Therapeutic Dilemmas column. The series comprised 32 reports, edited by Dr Beckman, of conferences held each Tuesday morning by staff members, residents, and interns at Columbia Hospital in Milwaukee.

Roentgen Riddles and Surgical Grand Rounds were among the shorter-lived series.

The most recent—and the longest running—series to appear in the *WMJ* has been the Clinical Cancer series.

The idea for the cancer series was conceived by Ernest S. Borden, MD. Dr Borden is the American Cancer Society professor of clinical oncology at the University of Wisconsin Clinical Cancer Center.

The first article appeared in December 1985. It was entitled "New discoveries in oncology: Potential applications to clinical practice," and was written by Henry C. Pitot, MD, PhD, from the McArdle Laboratory for Cancer Research.

In an introduction to the article, Dr Borden said the cancer series "aims to offer brief and practical digests of current perceptions and management approaches to clinical cancer." The articles would be pithy in nature, Dr Borden said, and he encouraged readers to contact the authors to discuss the topics further. Under Dr Borden's able guidance, the series has fulfilled its goals superbly.

Dr Borden, because of his stature among researchers and clinicians in the "cancer community," has been able to attract first-rate papers from around the state. He was the most successful coordinator that I encountered in my years with the *WMJ*; at one time I was overwhelmed with 18 papers that had to be reviewed for the series.

The scientific section of this issue of the *WMJ* is devoted entirely to the last of the Cancer Series, concluding with number 34. It has been a great pleasure working with Dr Borden, and the staff of the journal joins with me in expressing our appreciation for his splendid efforts and contributions in making the Clinical Cancer series so successful.

—Victor S. Falk, MD, Edgerton
Medical Editor Emeritus

The tribute to Ernest Borden, MD, by the emeritus medical editor of the *Wisconsin Medical Journal* is very appropriate. I wish to add my thanks to Dr Borden and to all the authors who provided manuscripts for the Clinical Cancer series.

—Richard D. Sautter, MD
Marshfield
Medical Editor

Contributors to the series

Listed by author in the order they appeared.

Henry C. Pitot, MD, PhD, *New discoveries in oncology: Potential applications to clinical practice*
Paul P. Carbone, MD, Chemoprevention: *An oncologist's view*

William Donegan, MD, *Lumpectomy or mastectomy*
James L. Weese, MD, *Colorectal cancer: Primary management*
Joseph J. Mazza, MD and William Friedenberg, MD, *Progress in acute leukemia*
Stanley L. Inhorn, MD, *The annual cervical pap smear*
James Cox, MD, *Treatment of cancer of the lung*
Hugh Davis, MD, *Systemic therapy of breast cancer*
William Stone, MD, *Screening and prevention of colorectal cancer*
Frank J. Rauscher, Jr, PhD, *Viral oncology*
David R. Nerenz, PhD, and Richard R. Love, MD, *Patient perceptions during cancer chemotherapy*
Howard Leventhal, PhD, and Timothy B. Baker, MD, *Strategies for smoking withdrawal*
Richard R. Love, MD, *Genetics and human cancer: Family history and common cancers*
Edward M. Messing, MD, *Early stage bladder cancer*
Ernest C. Borden, MD, *Progress in management of malignant melanoma*
R.R. Brown, PhD, *Diet and cancer: The fat-calorie relationships*
Robert H. Greenlaw, MD, *Resources concerning cancer available to the physician in the community*
Frank M. Graziano, MD, *Acquired immunodeficiency disease syndrome (AIDS)*
Stephen J. Lauer, MD, and Bruce M. Camitta, MD, *Management of children with cancer*
Richard V. Smalley, MD, *Bilologics as cancer treatment modalities*
William R. Friedenberg,MD, *New technologies in diagnosis and classification of malignancy*
Richard A. Steeves, MD, *Radiation therapy: Common questions and answers*
Roger W. Kwong, MD, *Cancer pain control: Use of nonparental analgesics*
Richard M. Hansen, MD, *Systemic therapy of colorectal cancer*
S. Vance Strother, MD, *Clinical management of lymphomas*
Andrew B. Crummy, MD, and John C. McDermott, MD, *Interventional radiology in cancer*
Edward J. Prendergast, MD, *The psycho-social aspects of cancer*
Frank E. Berridge, MD, *Gastric cancer*
Charles H. Diggs, *Cancer of the unknown primary site*
Marcia J.S. Richards, MD, James E. Bruckman, MD, and Howard J. Lewis, MD, *Curative radiation therapy for the primary physician*
Charles S. Cleeland, PhD, *Barriers to the management of cancer pain: The roles of patient and family*
Robert C. Ash, MD, and James T. Casper, MD, *Clinical applications and research advances in marrow transplantation*
Robert S. Witte, MD, *Follow-up of the "cured" cancer patient*
Roger W. Kwong, MD, *Supportive care of the incurable cancer patient*■

Clinical cancer: 30
Curative radiation therapy for the primary physician

Marcia J.S. Richards, MD,
James E. Bruckman, MD, and
Howard J. Lewis, MD, Milwaukee

THE PRIMARY AIM of curative radiation therapy is achieving local control of a malignancy with minimal late effects on the normal tissues. The patient is also frequently cured, but only if the incidence of occult metastatic disease is low or if there is effective systemic adjuvant treatment to prevent its reappearance. Radiation therapy may be used as the primary treatment, as an alternative to surgery, or in combination with surgery or chemotherapy (with or without surgery) to achieve a cure of cancer patients. Judicious use of radiation therapy may offer the cancer patient an equal or improved chance of cure compared to other alternative treatments—many times with a greater preservation of bodily functions or better cosmetic results.

Of 985,000 persons diagnosed as having cancer in 1988, 50% to 60% will receive radiation therapy during the course of their disease, half aimed at curing the patient. This means that in Wisconsin, with an estimated total of 19,500 cancer cases in 1988, about 5,850 patients should receive potentially curative radiation therapy.

Although radiation therapy is often used for symptom relief or palliative treatment in patients with advanced or widespread malignancies, it may come as a surprise that half of patients are receiving it as a curative treatment. As these patients are often evaluated and treated as outpatients, there may be infrequent interactions during this period with the primary physician. In addition, the physician may have little exposure to the use of

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radiation as a curative method and may, therefore, not fully appreciate its efficacy, especially if the radiation therapy facility is at some distance.

The purpose of this article is to review clinical situations in which radiation therapy may be used as a curative therapy and briefly discuss various available techniques. General principles will be emphasized, with specific sites used only for illustration. It is beyond the scope of this overview to present comprehensive survival and local control data.

Rationale

With the development of cobalt units for cancer treatment, radiotherapy entered the megavolt era, and, unequivocally, its potential as a curative agent has been clearly demonstrated in many different tumors (Table 1).

Malignancies in which radiation therapy is used to achieve a cure fall into three categories. First, the tumor may be inherently biologically responsive to radiation at low or moderate doses, as in Hodgkin's disease. Second, the tumor may require a high dose of radiation for control, but be located near normal tissues that can also tolerate such doses—the usual clinical situation for many head and neck cancers. Lastly, through the use of surgery or chemotherapy, either the volume of tumor may be decreased to a size that is potentially controllable with radiation, or the inherent tumor sensitivity to radiation may be increased, as is the case in postoperative treatment with radiation therapy and 5-fluorouracil for stage B2 or C rectal cancer.

Techniques

Radiation therapy uses ionizing radiation to eradicate malignancies. The most common method of delivery is with external beam therapy, in which treatments are usually delivered daily five times a week over four to eight weeks. The areas of treatment are determined by the extent of the primary tumor and its known or possible sites of regional spread. Normal tissues are protected from high doses of radiation, whenever possible, through the use of individually constructed shields and careful computer calculation of radiation dose distribution, with the practitioner selecting the best of several options. Most commonly, x-rays for treatment are produced by a linear accelerator of 4 to 25 million volts (MV), the higher energies giving greater doses at depth and also sparing the superficial tissues, which is an advantage in pelvic, abdominal and thoracic tumors.

Cobalt-60 units generate gamma-rays, identical in their effect to x-rays, but at a lower energy of 1.25 MV.

Electron beams, also produced by linear accelerators in a range of 4 to 25 MeV, are useful for treating superficial tumors as they deliver their dose within a range from the surface of 1.5 to 7.0 cm depth, which varies with energy; essentially no dose is delivered at deeper levels.

Orthovoltage, very low energy x-rays, may also be used for superficial tumors, most commonly for skin cancers, because of its limited penetration; it still delivers some radiation dose at depth.

Operative radiation therapy procedures, although used much less often, play an important role in curative radiotherapy because they allow the delivery of a higher dose of radiation to the tumor, often increasing the chance of local control. Brachytherapy procedures involve the placement of radioactive sources into or near the tumor, either temporarily or permanently. Intraoperative radiation therapy involves administering a single high dose of electron beam irradiation to the tumor or its bed at the time of a surgical procedure.

The response to radiation has been improved by the recent development of techniques such as hyperfractionation (delivering more than one treatment per day), which allows the administration of a higher total dose in a shorter overall time with similar normal side effects, hyperthermia, (the use of heat in conjunction with radiation), and the use of drug modifiers, most commonly chemotherapy agents, during radiation. All of these techniques may improve the responsiveness and control of many cancers.

Radiation therapy as the primary treatment. Radiation therapy alone is the treatment of choice in early stage Hodgkin's disease and potential or known abdominal spread in stage I or II seminoma of the testis and ovarian dysgerminoma (Table 2). These cancers exhibit an inherent sensitivity to radiation and have a low risk of distant spread beyond the treatment volume, leading to an 80% to 90% probability of cure.

Other clinical situations usually treated with radiation include stage IIB to IV cervical carcinoma, head

Table 1—Examples of improved survival with megavoltage equipment

Type of cancer	Five-year survival (%) kV x-rays	MV x-rays
Hodgkin's disease	30–35	70–75
Cervical	35–45	55–65
Prostrate	5–15	55–60
Nasopharynx	20–25	45–50
Bladder	0–5	25–35
Ovarian	15–20	50–60
Seminoma (testis)	65–70	90–95
Tonsil	25–30	40–50

Source: Report of the Panel of Consultants on the Conquest of Cancer. Washington, DC, US Government Printing Office, 1970.

Table 2—Types of cancer treated with radiation therapy as primary treatment
Hodgkin's disease—stage I and II
Testicular seminoma—stage I and II (abdominal spread)
Ovarian dysgerminoma—stage I and II (abdominal spread)
Cervical—stage IIB–IV
Head and neck (nasopharynx, posterior tongue, tonsil, etc.)
Non-small cell lung (inoperable)
Extramedullary plasmacytomas
CNS tumors (at inoperable sites)

and neck cancers at sites where surgery is not feasible (such as the nasopharynx), many regional non-small cell lung cancers, and CNS tumors at inoperable sites, such as craniopharyngiomas, brain stem and pineal region tumors, and some pituitary tumors. Although surgery may be the preferred method of treatment for certain tumors, many times the cancer is too advanced to allow resection without cutting through disease, or the patient may be inoperable or refuse surgical management. In these situations, the tumor must be at an early stage and at a site where radical doses of radiation can be delivered for a high probability of cure.

As an alternative to surgery. In some clinical situations, approximately equal cure rates may be obtained with either surgery or radiation treatment (Table 3). Radiation therapy may often be the treatment of choice because of its ability to preserve certain bodily functions, (eg, in early larynx cancer, where radiation therapy can result in an 80% to 90% chance of cure with good preservation of the voice.) Other early head and neck cancers and early rectal cancers may also be treated with preservation of organ function. In other sites, radiation treatment may produce better cosmetic results with equal cure rates, such as in early carcinoma of the breast where limited surgery and radiation therapy offer the same chance of cure as mastectomy, but with breast preservation. Skin cancers located near difficult areas for resection, such as around the eyelids or on the nose, have a 90% or better chance of control without the deformity incurred with resection.

It should also be kept in mind that in many of these cancers surgery can often still cure half or more of patients when local radiation fails. Such sequencing of therapy will allow many more persons to be cured while preserving organ function or achieving better cosmetic results.

Table 3—Types of cancer for which radiation may be an alternative to surgery
Larynx (stage I and II)
Cervical (stage I–IIA)
Oral cavity (early tongue, floor of mouth, buccal mucosa)
Breast (early)
Skin
Prostate (stage A, B, C)
Rectal (early)

As a surgical adjuvant. Radiation treatment when combined with surgery can increase the probability of cure in a variety of tumors. In this setting, surgery removes the bulk of the tumor, with radiation being delivered to treat known or probable microscopic local or regional residual disease. Radiation therapy may be used preoperatively, intraoperatively, or postoperatively (Table 4). Occasionally, combined treatment may allow a less radical operation to be done, also allowing better preservation of bodily function. The goal in all combined approaches is to eradicate subclinical disease located beyond the margins of surgical resection. When delivered before surgery, the aims are to decrease the size of a tumor to allow a complete surgical resection to be performed and to reduce the potential for dissemination at the time of surgery, both local and distant.

Combined treatment can also be effective in moderately advanced head and neck cancers where surgery alone would result in a 40% to 70% risk of local failure; this can be reduced to 10% to 20% with postoperative treatment. Some extremity soft tissue and bone sarcomas may be treated with wide local resection and postoperative radiation, preserving limb function, yet achieving equal rates of local control and survival as amputation. Other common areas for combined treatment include some rectal and endometrial cancers, CNS tumors, including high grade gliomas and incompletely resected low grade gliomas and meningiomas, and many localized recurrent malignancies.

In combination with chemotherapy. The combined use of chemotherapy and radiation for several sites is an exciting development that can result in a greater chance of local control, decreased risk of distant relapse, or both (Table 5). In some situations, this technique has allowed the omission of radical surgery without decreasing the chance of cure.

Table 4—Types of cancer for which radiation therapy may be a surgical adjuvant
Preoperative
rectum
breast (advanced)
endometrium
head and neck
Intraoperative
stomach
pancreas
rectum
sarcomas
Postoperative
lung
CNS tumors (high grade or incompletely resected)
soft tissue sarcomas
rectum
breast
endometrium
head and neck

Cancer of the esophagus or anus, or invasive bladder tumors treated with combined therapy can now be cured with preservation of function with equal or improved cure rates. For example, anal cancers—many advanced—have approximately an 85% local cure rate without anteroposterior resection when treated with radiation and concurrent chemotherapy. Combined treatment for esophageal cancer has resulted in rates of survival and local control similar to surgically resected patients, despite many patients having had more advanced local disease.

Many childhood tumors, such as Wilm's tumor, rhabdomyosarcoma, some brain tumors, and others, have yielded dramatically to combined therapy. An example of such success is Ewing's sarcoma, where combined treatment has increased the local control rate from 65% to 90% and improved two-year survival rates from 15% to 75%. Radiation may also be used to treat malignancies in which chemotherapy is the primary therapy to treat potential sanctuary sites (such as the brain in small-cell lung tumors and some forms of leukemia), to decrease the risk of relapse at sites of initial bulky disease (eg, in some lymphoma patients), or to treat primary chest disease in individuals with small-cell lung tumors.

Summary

Curative radiation therapy may be used alone as the primary treatment, as an alternative to or in combination with surgery, or in conjunction with chemotherapy. Judicious use of radiation therapy may offer the cancer patient an equal or better chance of a cure, many times with preservation of function or better cosmetic results. The role of radiation therapy in a particular patient is best determined by multidisciplinary consultation before major therapeutic decisions are instituted.

Table 5—Types of cancer for which radiation therapy may be used in combination with chemotherapy (with or without surgery)

Esophagus
Pancreas
Anus
Bladder
Childhood solid tumors
Small cell lung
Non-Hodgkin's lymphomas
Advanced head and neck
CNS tumors
ependymoma
medulloblastoma
lymphomas

Recommended reading

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Clinical cancer: 31

Barriers to the management of cancer pain: The roles of patient and family

Charles S. Cleeland, PhD, Madison

CANCER PATIENTS, their families, and health professionals all desire optimal pain control, and the means for such control are available. Nevertheless, pain is often poorly managed.[1,2] While the attitudes and practices of health professionals often contribute to poor pain management, patient and family beliefs and behaviors compound the problem.

The first principle to be accepted is that pain demands treatment. For adequate resolution, the demand must be understood, the means for satisfying the demand known and available, and the appropriate action taken. When pain is not adequately managed, both the patient and health professional are frustrated. The objectives of palliative care are less precisely defined than those of curative care by both the patient and health professional, allowing room for disagreement about whether these objectives have been met. Moreover, since competence in palliative care may not be reflected in longer survival times or other objective results, its importance is often undervalued.

For optimal pain control, patients must be able to communicate about their pain, provide feedback on the effectiveness of treatment, and comply with the requirements of the ther-

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apies provided. Potential problems exist at each step of the process.

Communicating about pain

Several reasons have been suggested for the unwillingness of many patients to inform health care professionals when they have pain and for often minimizing its severity. Studies of hospitalized patients with pain suggest that some patients feel that complaints about pain will distract the physician from the more important task of fighting disease.[3] This concern is understandable in situations where physicians have limited time with each patient. Patients feel that they have to assign priorities for the physician time available to them. They may identify the physician as the only care giver who is able to make decisions related to pain therapy.

In most treatment settings, there is no clearly identified and sanctioned means by which patients can register pain or report that pain is worsening. Families may compound the problem by trying to work out with the patient what is important to tell the physician and may encourage the patient to minimize his or her pain.

Patients may also want to be thought of as "good" patients, (ie, those who do not complain) to receive more time and attention from the health care team;[3] research appears to confirm these patient attitudes. A study by Harris et al[4] found that physicians ranked patients with unresolved pain near the top of the list of those with whom they least liked to spend time.

Patient feedback

For many of the reasons previously discussed, patients may also be reluctant to tell staff that a pain therapy is ineffective. They may also believe that pain is an inevitable result of their disease and its treatment and that expecting adequate pain relief is not realistic.

Many assumptions by patients about cancer pain are based on folklore. To document these assumptions, a representative sample of the population of Wisconsin was studied by the interview survey method.[5]

Nearly 50% of persons interviewed said they considered cancer to be very or extremely painful. Not only was cancer rated as significantly more painful than several other medical conditions, its treatment was also considered painful. Approximately 40% of those interviewed said they believed treatment was very or extremely painful, and an additional 40% said they believed it to be moderately painful.

Somewhat over 70% of those surveyed said they thought cancer pain could become so severe that a person would consider stopping life-prolonging treatment, and nearly 70% said the severity of cancer pain might cause patients to consider suicide. Slightly more than 60% of those interviewed associated pain with disease progression, and approximately the same percentage said they believed cancer patients usually die a painful death.

These attitudes and beliefs of the general public are presumably shared by most cancer patients and their families, suggesting that they, too, regard pain as the norm for both cancer and its treatment.

Patient compliance problems

Another barrier to adequate pain management is the lack of compliance by patients with the pain management regimen, which often entails narcotic analgesics. Suppositions about these drugs frequently limit patients' reporting of pain and make them unwilling to take them. Many patients feel that having to take narcotics signals that active treatment for their disease is finished and that they are near death. Patients may also be concerned that by taking strong drugs too early in the course of their disease, these analgesics won't be effective when they are really needed.[6]

Another concern of patients and families is that a patient taking narcotics to control his or her pain will be thought of as a drug addict.

Our survey regarding general attitudes about pain found that the public shares many of these misperceptions about narcotic drugs.[5] When asked what concern they might have should they need to take narcotics for cancer pain, about three fifths of those surveyed reported that they would feel much or extreme concern about becoming mentally confused; more than half were similarly concerned that they would have to take increasing amounts of narcotics; and 45% worried about the possibility of becoming addicted.

Finally, patients may not comply with analgesic regimens because they don't understand the rationale behind them, for instance, the necessity of maintaining the medication at a certain blood level to protect them from pain. They may also regard adjunctive medications such as tricyclic antidepressants, which are prescribed to promote sleep or to alleviate depression, as analgesics and not take them unless they have severe pain.

Solutions

Patient and family education about cancer pain and its treatment will help eliminate many needless problems in pain management. Patients, families, and the general public need to know that good pain control is achievable for the vast majority of cancer patients, without intolerable side effects. Patients need to know how to take their drugs and how to prevent the most common side effects, such as constipation.

The Wisconsin Cancer Pain Initiative, a cooperative effort between professional societies, the medical schools, state government, and patient groups, has made progress in educating those who work with cancer patients.

Health professionals and patients need to share the burden for communicating about pain. Patients need to feel they have permission to report pain and when pain treatments are

failing. Simple pain questionnaires routinely administered can be important tools for improving patient-health professional communication about pain. Quantifying subjective pain reporting over time will also reveal whether pain treatments are working, especially if changes in pain severity are noted in the chart. Most important, health care professionals who are aware that these patient and family concerns are widespread will be prepared to meet them.

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Clinical cancer: 32

Follow-up of the "cured" cancer patient

Robert S. Witte, MD, La Crosse

"WE THINK THAT we got it all." These are the words that all cancer patients want to hear after undergoing treatment for their malignancy. For some, that therapy will indeed be curative. For too many, however, a relapse will often be the case. The uncertainty of the future is a major concern to both the physician and the patient, and the restoration of health should be a common goal. Careful follow-up care by the physician can facilitate this return to health, but only if the agenda is broad enough to encompass all of the potential concerns of the patient. An "anything goes" attitude on the part of the physician can be very helpful to this end. The detection of associated medical problems, the diagnosis of relapses or second primary lesions, and psychosocial support for the concerned patient and family are among the more important aspects of follow-up care that should be addressed to ensure the patient's recovery and continuing good health.

Treatment complications

The primary treatment of cancer involves the use of therapeutic methods that may cause future medical complications. The application of radiation therapy to the neck or whole brain is linked to the subsequent development of hypothyroidism and hypopituitarism, respectively. Depletion of the body stores of vitamin B-12 following gastric resection will result in serious hematologic and neurologic sequelae if not replaced parenterally. Likewise, malnutrition due to pancreatic insufficiency following surgery or radiation therapy for pancreatic cancer can be ameliorated by the use of intracibal replacement enzymes.

Detecting disease relapse

The level of vigilance needed during the follow-up of the "cured" cancer patient to detect a relapse is determined by several factors. First, the history of the cancer is relevant. It is axiomatic that indolent cancers will need less frequent follow-up than more aggressive malignancies. An aggressive cancer is much more likely to relapse and cause potentially life-threatening complications over a shorter time than a slowly growing tumor. Thus, cancers with histories suggesting more malignant behavior need more frequent follow-up.

Second, the type of testing necessary depends on the nature of the recurrent disease one wishes to diagnose and the therapeutic methods available to treat such recurrences. Many cancers are associated with metachronous primary lesions within the same or contralateral organ. Other malignancies are linked with a high likelihood of the development of metachronous lesions in other sites. These second primary lesions are much more likely to be cured than a recurrence that represents metastatic disease. A listing of such neoplasms needing surveillance is found in the Table. It is important to search for and rigorously treat such primary lesions.

Aside from watching for second primary malignancies, one must also be alert for the development of metastatic disease. In diseases with a high likelihood of cure despite their metastatic nature, one must maintain intense vigilance. Germ cell tumors fall into this category. Relapses of germ cell tumors are often heralded by the elevation of serum tumor markers, such as alpha-fetoprotein or the beta subunit of human chorionic gonadotrophin. The detection of these markers in the absence of other

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clinically identifiable disease is an indication for systemic cytotoxic therapy. Furthermore, these tumors can grow rapidly. Therefore, it is recommended that surveillance—including a thorough history and physical exam, tests for serum tumor markers and chest roentgenograms—be performed monthly during the first year of follow-up and every other month for a subsequent year. There are, however, virtually no other solid tumors that grow as rapidly and are as susceptible to systemic therapy to warrant such intense follow-up scrutiny.

Nevertheless, some metastatic malignancies that are not curable may be treated effectively with currently available therapy. Breast carcinoma is a prime example, and data are available on how the intensity and quality of follow-up in breast cancer patients treated with surgery affects their prognosis. Scranton et al[1] analyzed a group of 254 women treated with surgery for stage II or III breast cancer and found that approximately 75% of recurrences were symptomatic, 10% to 20% were detected by physical examination, and only about 5% to 10% were diagnosed via testing procedures. Further analysis showed that evaluation intervals of three to four months would allow 50% of diagnosable relapses to become evident.

A similar experience was reported by Valagussa et al[2] where 77.7% of the relapses occurring in their cohort of 845 surgically treated, node positive breast cancer patients were detected by physical examination, history, or both.

Indeed, abnormalities detected on short-term, follow-up roentgenograms were often more controversial than diagnostic. This recurrent theme was likewise substantiated by Pandya's review of the Eastern Cooperative Oncology Group's experience in following 856 patients on postoperative adjuvant protocols.[3] He found that 74% of the recurrences were detected clinically without the aide of exhaustive and expensive ancillary testing. It seems abundantly clear that a good ear and a gentle hand are all that is routinely necessary in following breast cancer patients. The majority of the ancillary tests and radiographic procedures can be reserved for confirmation of the suspicion of recurrence occasioned by periodic history and physical examination.

These data were generated and substantiated in a cohort of cancer patients for whom additional therapy was highly likely to be useful in at least a palliative sense. More exhaustive or more frequent follow-up of patients whose cancers have similar or more inferior treatments with respect to frequency, quality, or duration of response is not likely to be any more beneficial. This notion is substantiated by data from the Mayo Clinic regarding the follow-up of colorectal cancer patients treated with surgery.[4] The authors concluded that periodic medical history, physical examination, and tests pertinent to the discovery of resectable metachronous primary lesions were all that was routinely indicated. A similar conservative approach can be taken for the majority of "cured" patients with the usual solid tumor malignancies.

Incident malignancies and commonly associated cancers

Initial malignancy	Associated cancers
Breast cancer	Breast cancer Female genital cancer Colorectal cancer
Colorectal cancer	Other colorectal cancer Female genital cancer Breast cancer
Head and neck cancer	Head and neck cancer Bronchogenic cancer Esophageal cancer
Ovarian cancer	Breast cancer
Hodgkin's disease	Acute leukemia Non-Hodgkin's lymphoma Sarcoma

Psychosocial needs

Our goal in the treatment of our patients is the restoration of health—not just physical health, but psychological and social health as well. Smith and Lesko from Memorial-Sloan Kettering Cancer Center have recently reviewed this topic.[5] Physicians need to understand the common psychosocial problems that may afflict patients to help them deal effectively with these problems. Most patients will express some amount of anxiety regarding the following:

- uncertainty about the future;
- intrusion of the past traumatic experience on his or her current life;
- persistence of distressing physical symptoms; and
- changes in self-image.[5]

Lending a sympathetic ear and reassuring and educating our patients regarding the frequency and the normality of these feelings will often be all that is necessary to help them resolve these distressing symptoms.

Cancer survivors often have trouble becoming resocialized in the work place, at home, and in day-to-day interpersonal relationships. It is important to realize that these psychosocial problems exist, can significantly contribute to morbidity, and

can usually be dealt with by an "anything goes" approach during the follow-up encounter. The patient or a family member must feel comfortable discussing issues relevant to the patient's physical and psychosocial health.

In summary, the "cured" cancer patient has many concerns that need to be addressed. The physician must be cognizant of the common medical problems likely to befall these patients to avert unnecessary morbidity. The physician also needs to watch carefully for the development of recurrent disease so that effective curative or palliative therapy can be initiated, while at the same time being mindful that a careful medical history and physical examination are often all that are necessary to detect the majority of these relapses. The physician also needs to allow time for patients to discuss their psychosocial problems. By keeping these tenets in mind we will most effectively facilitate the health of our cancer patients in all spheres.

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Clinical applications and research advances in marrow transplantation

Robert C. Ash, MD, and James T. Casper, MD, Milwaukee

MARROW TRANSPLANTATION, the subject of more than 20 years of active clinical and basic research, is now increasingly used to treat pediatric and adult patients with previously lethal hematologic diseases, congenital immunodeficiencies, inborn metabolic diseases, and both hematologic and nonhematologic neoplasia.[1] Awareness of the evolving applications of this treatment method is, therefore, of growing importance to physicians who encounter these patients. Although use of both allogeneic (ie, nontwin donor) and autologous (ie, self donation) transplants is expanding, this review will focus primarily on applications of allogeneic marrow transplantation (see Table 1).

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Neoplastic disease

Neoplastic diseases, especially acute and chronic leukemia, are those disorders for which marrow transplant is most frequently done. Seventy-five percent to 90% of adults and 60% to 80% of children with acute nonlymphoblastic leukemia (ANLL) will

Table 1—Applications of allogeneic bone marrow transplantation

Severe aplastic anemia
Severe immunodeficiency diseases
Acute leukemia (lymphoblastic and myelogenous)
Chronic myelogenous leukemia
Paroxysmal nocturnal hemoglobinuria
Osteoporosis
Neuroblastoma
Other chronic leukemia
Poor prognosis lymphoma
Severe hemolytic hemoglobinopathies
Inborn errors of metabolism
Selected chemotherapy responsive solid tumors
Myelodysplastic syndromes with karyotypic, morphologic, or clinical features that predict leukemic evolution or a high likelihood of death from cytopenias

eventually fail standard chemotherapy. For these patients, allogeneic or syngeneic (ie, identical twin) marrow transplants have historically been the only hope of cure. For ANLL patients who have achieved a first remission, the roles of consolidation chemotherapy versus transplant remain somewhat controversial. Nevertheless, for young patients with ANLL who have HLA-matched siblings, most studies have demonstrated that marrow transplantation achieves actuarial leukemia-free survival (LFS) rates of 45% to 70%, results not generally achieved by chemotherapy alone.

Patients whose ANLL has arisen from a prior myelodysplastic syndrome should be considered for early transplantation, since chemotherapy alone seldom produces a cure. Similarly, for patients with ANLL phenotypes that usually fail chemotherapy, such as monocytic (M5), erythroleukemic (M6) and megakaryocytic (M7) variants, early transplant is preferred.

In acute lymphoblastic leukemia (ALL), chemotherapy in standard risk pediatric patients will now cure at least 60% to 70% of patients, so that transplant for most pediatric patients is reserved for salvage therapy. Pediatric ALL patients who should be considered for transplant in first remission include those with the Philadelphia chromosome (t9,22), those with the 4,11 translocation, and those with B-cell phenotypes (particularly those with high white counts and less than 2 years of age).

For ALL patients over 16, results with chemotherapy alone have also been less satisfactory, so that transplants in first remission should be considered, especially for young adult patients with high white counts (>30,000/μL) or with one of the above high-risk ALL phenotypes.

In chronic myelogenous leukemia of both adult (Ph1+) and juvenile variants, marrow transplantation is the *only* therapy demonstrated to be curative. Results are superior for transplants performed in early chronic phase disease (45% to 70% LFS rates) as compared to transplants in blastic and accelerated phases (12% to 25%), so that patients should be evaluated for transplant early after diagnosis.

For lymphoma refractory to standard treatments and for some chemotherapy- and radiotherapy-responsive

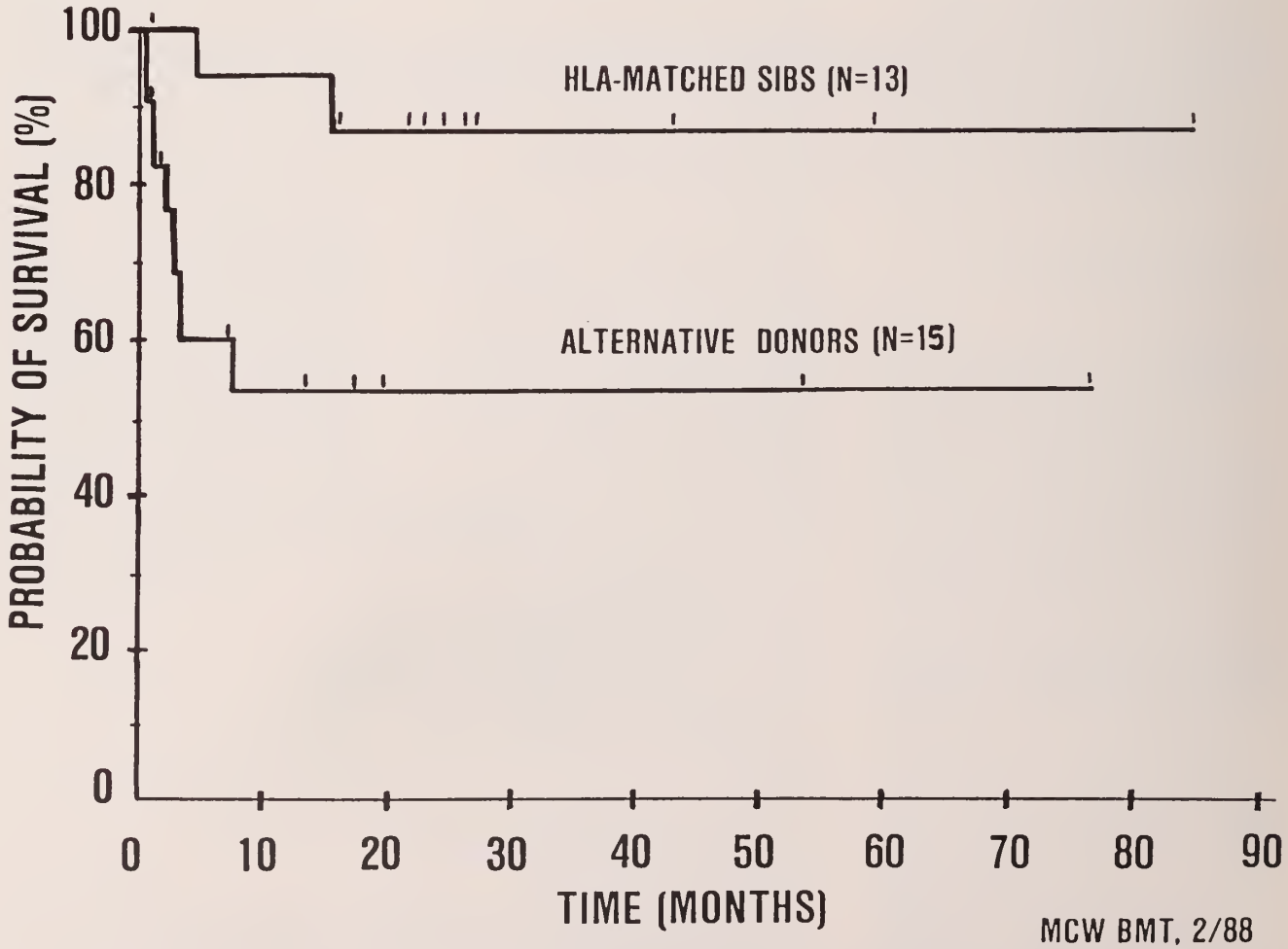

Fig. 1a—Kaplan-Meier actuarial survival for all consecutive non-neoplastic disease transplants (includes aplastic anemia, immunodeficiency, and inborn errors) performed by the Medical College of Wisconsin transplant team since the beginning of institutional transplant activity in 1980; data analyzed 2/28/88. Tick marks indicate surviving patients.

nonhematologic cancers, marrow transplantation allows the escalation of dose without limitation by marrow toxicity, affording a potentially greater chance of cure. For young patients with suitable donors who have marrow involvement, allogeneic transplant may be considered.

Patients who are either too old for allogeneic marrow transplant or who do not have suitably matched donors may be considered for autologous transplant. Autologous transplants have most often been used for patients who do not have marrow involvement; newly developed means for "purging" the marrow of residual neoplastic cells, however, may allow autologous transplantation even for patients who have had previous marrow involvement. These purging methods, utilizing either neoplasia-directed monoclonal antibodies or incubations with such tumoricidal drugs as 4-hydroperoxycyclophosphamide or merocyanine-540 may also be used for patients with acute leukemia in remission who are not candidates for allografting. A schematic view of these treatment considerations for patients who may be transplant candidates is shown in Fig 1.

Advances in treatment

Major problems in allogeneic transplantation are summarized in Table 2. Advances against many of these problems now offer hope for improved results in both HLA-matched and alternative donor transplants. Improved means for graft-versus-host disease (GVHD) prophylaxis and treatment have come with drugs like cyclosporine and thalidomide and utilization of T-depletion methods. Although early T-depletion trials encountered such problems as increased graft rejection, leukemic recurrence, and B-cell lymphoproliferative neoplasia, subsequent refinements can now produce high rates of sustained engraftment with apparent preservation of the antileukemic effect.[2,3]

Improved antiviral[4] and antifungal[5] therapy, improved nutritional care, and new biologics and antibiotics have each contributed to better support for the recovering transplant patient. Conditioning regimens under investigation may produce improved antitumor effects and engraftment rates with lower toxicities than regimens historically employed. More appropriate timing for transplant in the various disease settings should further improve outcomes.

Actuarial survival rates for allogeneic transplants performed at the

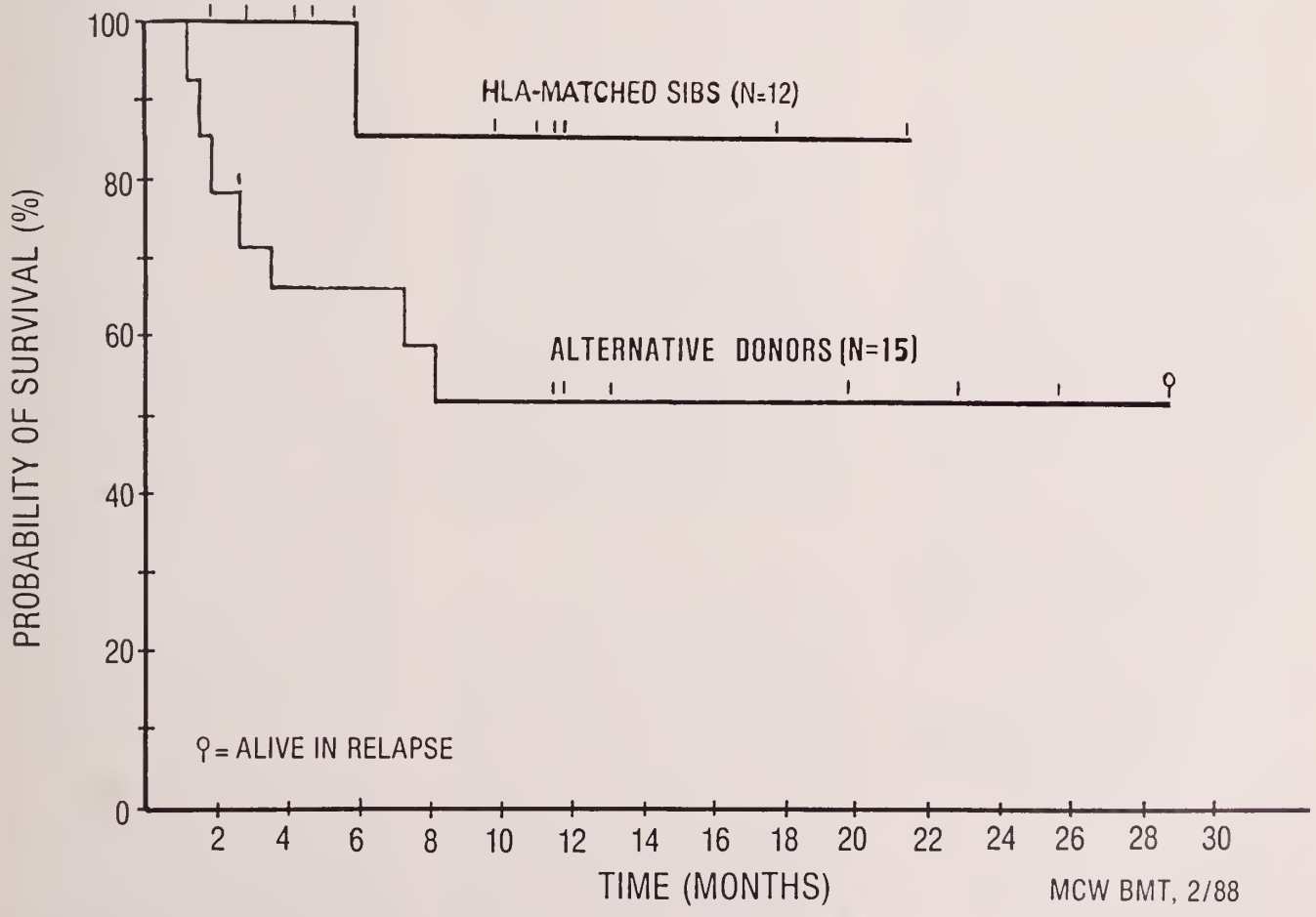

Fig. 1b—Kaplan-Meier actuarial survival for all "early" or "good-risk" neoplastic disease transplants (ie, acute leukemia in first remission and CML in chronic phase) done by MCW transplant team with current protocols; data analyzed 2/28/88. With the single exception indicated by open tick mark (a patient surviving with recurrent CML), tick marks indicate leukemia-free survivors.

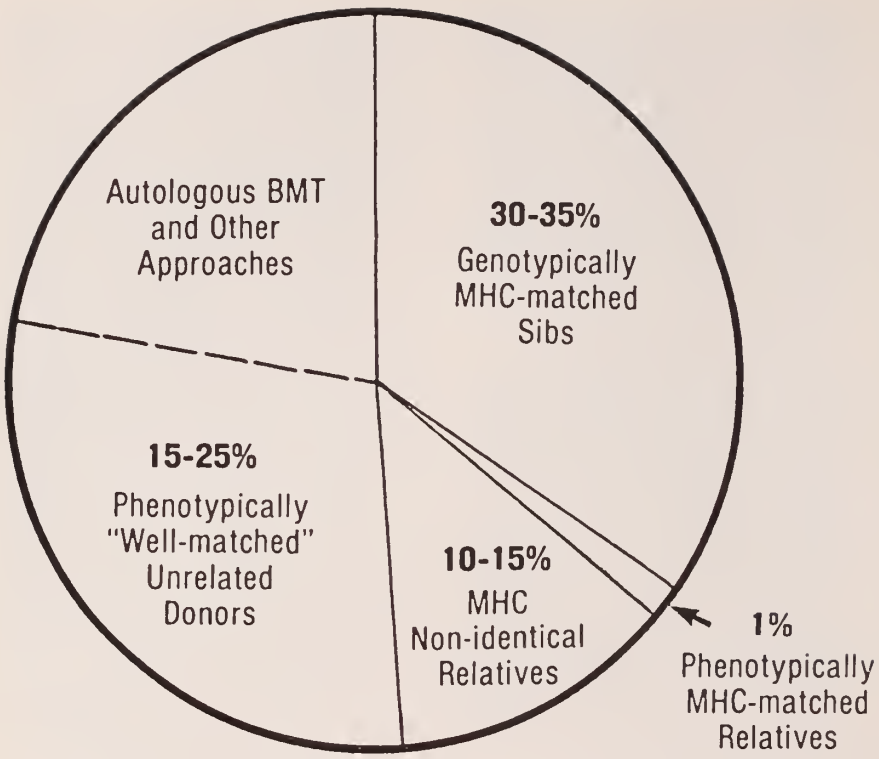

Fig. 2—Treatment approaches by marrow source for potential transplant patients.

Medical College of Wisconsin are shown in Figures 1a and b. These results show that transplants for appropriate diseases can be effective in a high percentage of patients (84.6% survival rate for non-neoplastic diseases and 85.6% LFS rate for good-risk neoplasia with HLA-matched sibling transplants). It should be emphasized that alternative donor transplants (ie, those with partially-matched related and unrelated donors) are also effective, with current results at this center (53% and 51% for non-neoplastic diseases and good risk neoplasia, respectively) approaching historic outcomes in HLA-matched sibling transplants.

Results for patients with more advanced neoplasia (CML in accelerated or blastic phase, ANLL in second and subsequent remission and relapse, ALL in second and subsequent remission and relapse, refractory lymphoma, myelodysplasia, etc) are lower (LFS plateaus of 15% to 35%), reflecting patient disease state, medical condition, and match category (data not shown).

Table 2—Major obstacles in allogeneic marrow transplantation
Finding a suitable donor
Graft-versus-host disease (GVHD)
Rejection
Infections/immunodeficiency
Neoplastic disease (leukemic) relapse
Non-hematopoietic toxicity

Aplastic anemia and immunologic disorders

In patients from infancy to about age 50, allogeneic marrow transplantation is the treatment of choice for those with severe aplastic anemia (SAA) who have HLA-matched sibling donors. Antithymocyte globulin (ATG) produces significant hematologic responses in 30% to 50% of SAA patients, so that it is usually employed for patients who do not have HLA-matched siblings. Data from alternative donor transplants (ie, with partially matched relatives and closely matched nonrelated individuals) is such that these mismatched transplants should be considered for suitable patients who fail ATG (see Fig 1a).

Patients with severe aplasia should be evaluated early at centers experienced with these several approaches so that appropriate diagnostic studies (to exclude other causes of pancytopenia) and extended family and nonfamily donor searches can be undertaken prior to starting definitive treatment.

Similarly, for patients with severe congenital immunodeficiencies (such as severe combined immunodeficiency disease, Wiskott-Aldrich syndrome, Chediak-Higashi syndrome, chronic granulomatous disease, and other lymphocyte and granulocyte dysfunction syndromes), allogeneic transplantation is usually the only curative therapy. Alternative donor (mismatched) transplants are also increasingly successful in these disorders (see Fig 1a). Recognition of these diseases in the early months of life and referral to specialized treatment centers is important.

Summary

Allogeneic and autologous marrow transplantation are increasingly used for the treatment of lethal blood diseases and cancer. Advances in transplant supportive care, graft-versus-host disease prophylaxis, and in techniques for mismatched transplants for patients who do not have matched sibling donors are improving outcomes and broadening the scope of transplant applications. Awareness of these evolving techniques should allow clinicians dealing with such patients to plan more successful treatment in selected diseases.

Acknowledgements

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Clinical cancer: 34
Supportive care of the incurable cancer patient

Roger W. Kwong, MD, La Crosse

ONE HALF OF PATIENTS diagnosed with cancer are incurable and may live from a few months to several years. For these patients, cancer is a chronic disease. With appropriate therapy, the incurable patient's disease may be controlled for long periods. Supportive care, which may include anti-cancer therapy, differs from hospice care, which focuses on the palliation of symptoms for the dying patient. The success of supportive care depends on good communication among the patient, family and care providers; setting specific goals regarding symptom control is also needed. This paper will discuss the care of those patients for whom the likelihood of cure is very low or nonexistent, but for whom there should be no limit of care. It will detail the philosophy of supportive care, methods of alleviating symptoms, and the setting of goals.

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The philosophy of supportive care

The goal of supportive care is to maintain the highest possible quality of life as defined by the patient and care providers. This includes controlling the symptoms of illness and establishing and fulfilling appropriate goals. Supportive care addresses the physical, emotional, and social aspects of illness. A supportive care team includes physicians, nurses, social workers, occupational and physical therapists, clergy, dieticians, pharmacists, psychologists, and volunteers. Each team member applies his or her special skills in a coordinated effort to address the concerns of everyone affected by the person's illness, which may include the physician and other team members.

Pain control

Pain is the most widely feared symptom among cancer patients. To achieve optimal pain control, the physician must identify the etiology of pain with a careful medical history and physical examination. Cancer pain is best treated by treating the cancer, which may involve palliative chemotherapy, radiation therapy, or surgery. When the cancer pain, or pain unrelated to the disease, cannot be corrected or prevented, it should be controlled.

Analgesics. In a pain control regimen, the physician commonly uses oral analgesics first. A step ladder progression, beginning with over-the-counter analgesics, is the model. The usual treatment for mild pain is acetaminophen or aspirin, two tablets every four hours; if this is not effective, up to 2400 mg of ibuprofen in divided doses can be tried. Regularly scheduled administration is more effective than as needed (PRN) dosing.

For moderate pain, the second step on the ladder, the clinician can prescribe a schedule III narcotic, such as acetaminophen tablets, 325 mg, with codeine, 30 mg, two tablets every four hours.

The schedule II narcotic agents make up the top ladder step for severe pain. Dihydromorphinone HCl tablets, 4 to 8 mg every four hours, or morphine sulfate in tablet, oral solution, or slow-release tablets, 30 to 300 mg per day in divided doses, can often provide effective pain relief.

The proper dose of a narcotic is one that relieves pain with acceptable side effects. When comfort is the goal, the amount of narcotic administered should be limited only by the appearance of side effects that interfere with the patient's comfort. Sedation, mild confusion, and even respiratory

depression may be acceptable when death is imminent.

Most narcotics are now available in multiple forms, eg, tablets, oral solution, rectal suppositories, and injectable solutions, and working closely with a pharmacist will assure the physician that the needed narcotic will always be available. Regarding the parenteral administration of narcotics, the intravenous (IV) route is preferred because the drug is more dependably absorbed and because it causes less discomfort to the patient. Intravenous morphine can usually control most severe cancer pain, and it can be administered at doses from 0.25 to 30 mg or more per hour by infusion pumps. Patient controlled analgesia pumps can be very effective in administering intravenous morphine and are available for outpatient use. Codeine, 15 to 60 mg given orally (PO) four times daily, may be used to control an intractable cough or sense of dyspnea unrelieved by oxygen.

Other pain control methods. Cancer pain control may involve not only the effective use of analgesics, but also the skills of a psychiatrist, chaplain, and surgeon, and empathy and availability are always important components in any pain control program. Relaxation techniques, hypnosis, and the working out of unresolved grief and anger may also help ease suffering expressed as pain. Other treatments for controlling pain and maintaining a patient's independence include splints and braces, transelectrical nerve stimulation, nerve blocks, and portable pumps for injecting intrathecal or epidural narcotics. This journal recently published an article in this series about cancer pain control,[1] and the Wisconsin Cancer Pain Initiative has produced an excellent, concise, pocket-size handbook on the subject.[2]

Other symptoms

Nausea and vomiting. Nausea and vomiting resulting from medication, treatment, metabolic abnormalities, or obstruction are also common problems for the cancer patient. Antiemetics are part of the first line of therapy when nausea or vomiting are not caused by obstruction. Prochlorperazine, 10 mg tablets or capsules every eight hours, or 25 mg rectal suppositories every 12 hours is most commonly used. The administration of metoclopramine, 10 mg IV every six hours, or sedatives such as lorazepam, 1 to 3 mg IV every two to four hours, may also be useful in the institutional setting. A change in analgesic medication or the addition of a potentiator such as hydroxyzine, 25 mg PO every four hours, may also decrease nausea. Nasogastric suction may help if antiemetics or modification of therapy or medication is unsuccessful. Nausea and vomiting may also be alleviated by correcting metabolic abnormalities such as hypercalcemia, hyponatremia, hyperbilirubinemia, or azotemia.

Bypass surgery for bowel obstruction may be considered if a single focus of potential obstruction can be identified and if the patient's life expectancy is only two to three months. For those who are not candidates for bypass or major surgery but have a reasonable life expectancy, gastrostomy placement for suction or gravity drainage can be considered as an alternative to the placement of a nasogastric tube, which can be uncomfortable for the patient. Percutaneous endoscopic gastrostomy placement can be achieved without general anesthesia.

Elimination problems. Elimination may be a problem in patients who become weak or lose bladder or bowel control. A silicon or teflon bladder or suprapubic catheter or a rectal mushroom catheter may greatly reduce the amount of care needed, as well as the strength required of the care provider. Incontinence bags or adult diaper undergarments may be useful when skin irritation is not a concern. Bowel training programs with stool softeners (DSS or bulk agents), laxatives (Milk of Magnesia or Dulcolax), and enemas may make stool elimination more comfortable and predictable and have advantages for nursing care. Diversion of stool via a colostomy or urine via a ureterostomy may also be warranted in selected circumstances. These may help the patient regain a measure of comfort and dignity. The placement of ureteral stints or a nephrostomy tube percutaneously under radiographic control may preserve renal function and prevent uremia. They should be considered if the creatinine level is higher than 2 mg in a cancer patient receiving active therapy and 5 mg in one who is not.

Biliary diversion percutaneously with radiographic guidance or endoscopically can effectively control the puritis and nausea of bile levels above 15 mg. In patients receiving active therapy with hepatically metabolized drugs, levels below 5 mg may be preferred.

Effusions. Malignant serous effusions that cannot be controlled with antitumor therapy or the removal of fluid less than once every one or two weeks may still be controllable. Pleural effusions may be controlled with chest tube drainage and sclerosis, with the infusion of tetracycline, 15 to 20 mg/kg (maximum of 2000 mg) in 50 cc of saline solution, followed by an additional 50 ml of saline to flush the tube.

The pain of sclerosis may be decreased by giving 20 ml of 1% lidocaine before the tetracycline. Additional analgesics are usually needed. Peritoneal fluid buildup may be controlled partially with spironolactone starting with 50 mg twice or three times daily. Peritoneal venous shunts and pericardiopleural windows or intracavitary catheters may also have their place in intractable or acute situations.

Mobility problems. A cancer patient may find mobility increasingly difficult because of weakness, pain, or deformity. The loss of mobility results

in a loss of independence and the increased risk of pressure sores. Pressure sores may be prevented or delayed with the use of pressure reducing pads for the bed and chair including a sheep skin, "egg crate," or air or fluid pad. Any persistent redness of the skin should be treated by relieving the pressure. Assessment of the home by a nurse, social worker, or occupational or physical therapist can assist in modifying the home to lessen physical barriers. The installation of equipment such as shower stools or wands and grab bars will give the patient more independence and lessen the load on care providers. Many of these items are available through the gift and loan service of the local American Cancer Society unit, service clubs, county health and visiting nurse services, and hospices.

Neurological problems. Brain and spinal cord metastases may be controlled with radiation therapy. The best results are usually found in patients whose neurologic symptoms are resolved with dexamethasone, 4 mg PO every six hours. CNS metastasis should always be suspected in a patient with advanced cancer who develops any neurologic change and diagnosis and treatment undertaken promptly.

Nutritional concerns. Nutritional problems are almost universal in cancer patients. Because eating is a major occasion for social interaction, a cancer patient who is unable to eat with family and friends may become isolated. The common belief is that an ill person would he healthier if only he or she would eat. Anorexia from advanced disease makes eating difficult, and families need to understand that if a patient were healthier he or she would be able to eat better. Oral supplements such as Ensure, Meritene, and Carnation Instant Breakfast are commonly used and can be sustaining alone. They should be considered when a patient has lost more than 10% of usual body weight or falls below the lower limit of ideal body weight, or when the serum albumin level falls below normal.

For the patient with a functioning gastrointestinal tract who cannot maintain a stable weight, a feeding tube, if accepted, can be used for feeding and the administration of medicine. The techniques can generally be mastered by patients and care providers. A tube may also be necessary in patients unable to take enough fluids orally to prevent dehydration. Total parenteral nutrition is usually not warranted except in short-term situations when active therapy is being given with some expectation that sufficient improvement will result. It is possible to sustain a person with IV fluids alone. Two to three liters of 10% dextrose with one-half normal saline solution with KCl added may be adequate to prevent thirst and dehydration. Hunger is usually not a problem in advanced disease. The administration of IV fluids in the home is feasible using one of the many central venous access devices, which have greatly increased patient comfort.

Anemia, which may cause dizziness, chest pain, shortness of breath, or severe fatigue, is an indication for transfusion. In patients over 60 years, those receiving radiation therapy or oxygen, or those with bleeding or a high risk of bleeding, the hemoglobin level should generally be kept above 10 g/dL. Younger patients and others may tolerate levels down to 8 to 8.5 g before becoming symptomatic. The potential for massive hemorrhage requires planning in advance as to what the limits of treatment will be; this may include a limit on the number of units transfused per bleeding episode or over time, such as three units per week. Hemorrhage is one of the least tolerated symptoms in the home setting.

Infections. Infections from tumor wounds can be common in the patient with advanced cancer and may range from asymptomatic to extremely uncomfortable for both the patient and care providers. Antibiotics are generally warranted in symptomatic situations. Antipyretics may control fever with temperatures of 38.5 °C or chills. Acetaminophen, 650 mg PO every four hours, or sulindac, 200 mg PO twice daily, may also suppress tumor-related fever. Wound debridement and good topical care may also make tumor-related superficial infections tolerable. When the infection does not respond to treatment, surgical excision of the tumor may be warranted. Draining sites may be controlled by pouching procedures with help from an enterostomal therapist.

Coping difficulties. For the patient with cancer, problems in coping with the situation are common. To foster a sense of control in what otherwise seems a situation beyond their control, the physician should involve the patient and family in setting goals and choosing therapy; when possible the patient's goals and wishes should have priority. Some patient requests may not be possible to fulfill, however, and alternatives should offered along with explanations of the reality of the situation. Open communication facilitates coping and improved understanding and acceptance.

Coping effectively with a hostile, demanding, or confused patient requires that care providers have an understanding of the cause of the behavior and its management. They may also need positive reinforcement for their efforts. Care here may be directed more to the care providers than the patient.

Setting goals

The physician and other members of the supportive team need to guide the patient, family, and care providers in setting goals. All those involved in setting goals should understand what the situation is, whether certain goals are realistic and whose goals they are.

For many patients, being at home is a common goal. The advantages of being at home include physical com-

fort, privacy, a sense of familiarity and security, a feeling of continuity with one's normal life, autonomy, closeness with family and friends, family involvement in care, availability of help, a tolerance of dependence, convenience, and even lower cost;[3] these are generally associated with one's quality of life. Fulfilling the cancer patient's goal of being at home is possible when there are adequate care providers. Immobility, incontinence, vomiting, confusion, and hemorrhage are difficult to handle at home for any length of time, however, and often result in institutionalization, whether temporarily or until death. Increased professional home nursing or respite care may allow a patient to remain at home longer.

Symptom control is a universal goal for cancer patients, and choices must be made about how it can be achieved. The methods discussed above may be indicated, but may not be consistent with the desires and goals of the patient. Certain procedures or hospitalization to control symptoms may not be as desirable as being at home if death seems imminent.

A frank discussion of the possible outcomes of different treatments, potential complications, and anticipated future problems may not only help allay unwarranted fears, but also allow the patient and family to define their priorities for what may be a limited future. Decisions are needed on the desirability of surgery, radiation or chemotherapy treatments, cardiopulmonary resuscitation, supportive measures, such as transfusions and feeding tubes, and even, perhaps, organ donation and an autopsy. Making an appropriate plan is easier for the patient who has stated clear, reasonable goals that are understood, if not always accepted, by all parties concerned. Communication is the key to defining therapy appropriately to meet the patient's and family's goals.

Summary

Supportive care is the appropriate use of the usual curative care skills to maintain the highest quality of life for a cancer patient when cure is not possible. The physician should not assume that all problems are cancer-related and cannot be resolved or improved with specific therapy until a thorough evaluation has been made. Many excellent references on the subject are available.[3-5] Caring for the dying patient and his or her family can be difficult, yet rewarding. William Osler said, "The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head."[6]

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Planned Parenthood tests for AIDS

Less than 1% of those tested for the AIDS virus at Planned Parenthood of Wisconsin's three testing sites tested positive during the first eight months of screening, according to the agency. The clinics, located in Appleton, Madison and Milwaukee found that only four of 384 people tested were positive for HIV infection. Planned Parenthood officials said they are seeing many low-risk clients, some who have been referred from other sites that have backlogs. The agency also reported that 3% of those seeking testing were men and the ages of those tested ranged from 13 to 66, with the average age being 30.■

Impaired physician

Persons interested in the Impaired Physician Program may call 608-257-6781, or toll-free in Wisconsin 1-800-362-9080, to explain their concern to John LaBissoniere, Sally Wencel or H.B. Maroney of the SMS staff. The caller's identity will be kept in complete confidence.

Volunteer.

American Heart Association

Healthwatch brochures available again

The use of smokeless tobacco is a growing health hazard in Wisconsin, especially among adolescents, according to the Wisconsin Department of Health and Social Services. A new brochure that discusses the problem in an easy-to-read question-and-answer format is now available from the SMS Division of Communications at a cost of $.10 each; a free sample will be sent on request. A brochure on how to spot malignant melanoma is also available. Both pamphlets are suitable for display in physician's waiting rooms. For more information, contact the SMS Division of Communications at 1-800-362-9080 or 608-257-6781.■

Quacks sell hope, not health care

Although modern medical quacks use the latest technology to sell a variety of New Age nostrums, their basic techniques and appeal have remained unchanged, according to the head of a national organization dedicated to fighting health fraud.

"Quacks sell hope" was the message delivered by William Jarvis, PhD, Director of the National Council Against Health Fraud, at a recent conference sponsored by the Winnebago Mental health Institute in Neenah. They "take advantage of what people are afraid of and offer hope and deliverance," Jarvis told an audience of about 150 health professionals, mainly dieticians. The conference, entitled "Snake oil to miracle merchants," was also sponsored by the Northern Wisconsin Dietetic Association—Fox Valley Dieticians, the Dairy Council of Wisconsin and the Wisconsin Division of Health.

According to Jarvis, medical quacks also operate by undermining people's confidence in established medicine and, in the case of health food cultists, even in their food and water supply. Medical quackery has become a form of "urban folk medicine," he said, capitalizing on "what everybody knows" to sell worthless products. ("Everybody knows that sugar causes hyperactivity" or "Everybody knows that positive thinking can help heal disease.")

Although medical quackery can never be completely eradicated, according to Jarvis, physicians can help keep their patients away from quacks by spending more time with them and communicating more. "Patients need a strong feeling that their doctors care about them," he said. Medical quacks are ready to fill this need if physicians fail.

Scope of the problem

Jarvis said Americans are estimated to spend anywhere between $25 billion and $100 billion each year on medical remedies and devices that are ineffective or unproven, and the elderly appear to be the most vulnerable. Common health concerns targeted by quacks are arthritis, cancer, diabetes, and fitness and weight loss. The current anti-regulatory mood in Washington has contributed to the problem, Jarvis said.

New schemes for selling these products include pyramiding, in which customers become salesmen, the use of slick testimonials, and telemarketing. Using telemarketing, a quack may sell a $300 to $400 supply of vitamins by phone and have them charged to the customer's credit card and delivered by private postal companies—thus avoiding postal regulations.

Health fraud causes many kinds of harm, Jarvis said, both to the patient and to society. Besides the damage to their pocketbooks, patients may suffer physical harm, such as vitamin toxicity, or psychological damage, or they may fail to seek needed medical treatment. Believing in the nonsense cures promoted by quacks also undermines people's confidence in health care professionals and harms society as a whole (eg, the "Twinkie defense," used successfully in a San Francisco murder trial, relied on false claims about junk food).

Unfortunately, people often blame the victim of health fraud schemes more than the perpetrator ("If he is that gullible, it's his own fault"), and, therefore, the legal prosecution of quacks receives a low priority. People may also hesitate to criticize those who use fringe treatments, such as homeopathy and herbal remedies, which are based on ancient folk remedies, because they are unwilling to offend other people's beliefs.

Jarvis also pointed out that a few physicians become involved in health fraud themselves; one study cited found that 36% of so-called alternative health care providers were physicians. These physicians turn to quackery for a variety of reasons, Jarvis said. They may be bored, suffer from low self esteem, experience reality shock, such as a patient's death, or find that the practice of medicine encroaches on their religious beliefs. Others may be motivated by greed or driven by their own egos.

How quacks operate

Medical quacks use a variety of tricks to sell their products. Some of these are:

- Engaging in spectacular events to attract attention (eg, walking on hot coals);
- Making the treatment seem plausible by mixing common sense with

nonsense or using double talk ("Cancer can't be cured; the patient can" or "I don't treat diseases, I treat people");
- Presenting false testimonials;
- Manipulating the news media by planting news stories or appearing on TV talk and health shows;
- Using psychological gimmicks in the clinic to manipulate their patients;
- Taking false credit ("You may not be cured, but at least it hasn't spread"); and
- Avoiding blame ("You feel bad because you're actually getting better").

Jarvis also said these practitioners employ a variety of effective arguments to handle attacks from legitimate medical groups and government agencies. Common defense arguments are:

- "They criticized Galileo, too;"
- "Physicians only want to protect their own interests;"
- "They're trying to take away your freedom of choice;"
- "Science doesn't have all the answers."

Another technique, Jarvis said, is to employ attorneys to harass their critics.

Identifying the quack

Jarvis offered several practical tips for spotting medical quacks. He said they usually have spurious credentials and use invalid assessment methods (such as diagnosing a supposed vitamin deficiency by examining the iris of the eye). They also often engage in inappropriate prescription practices and emphasize costly nutritional supplements. Another hallmark of the quack is that he or she engages in direct sales of products.

The modern health quack, Jarvis said, often bills himself or herself as a nutritional consultant and uses scam testing and phony treatments for various allergies and diseases. Some of these are cytotoxic and yeast tests for supposed allergies, hair and teeth analysis, naturopathy, chelation therapy, craniopathy and herbal crystallization.

Jarvis is a professor of health education at Loma Linda School of Medicine in Loma Linda, Calif. The National Council Against Health Fraud is an all-volunteer nonprofit organization with about 2,000 dues-paying members. Jarvis says the group's goal is to ensure that health care products are safe and effective for their intended purpose, accurately labelled, and truthfully advertised. ■

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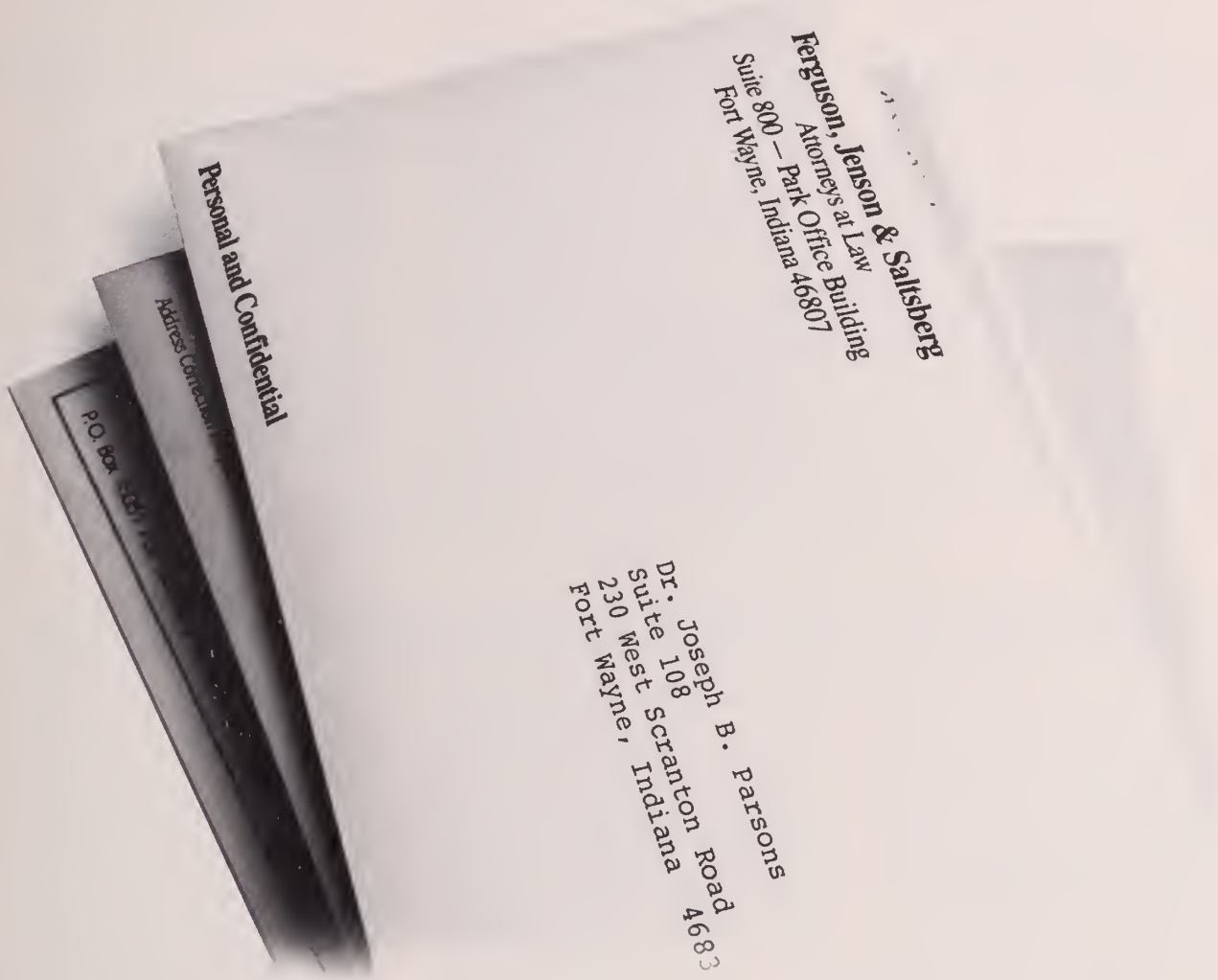

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Five investigational new drugs available

Physicians can now obtain five drugs under the Food and Drug Administration's (FDA) treatment investigational new drug application (IND) process. These drugs are included in current treatment protocols and are intended for use by patients with serious or life-threatening illnesses for which there is no satisfactory alternatives.

The following five drugs are now available under the treatment IND program:

- Selegiline, for the treatment of Parkinson's disease as an adjunct to standard forms of therapy in patients who have experienced difficulty with these therapies (sponsored by Somerset Pharmaceuticals, Inc, of Denville, NJ);
- Clomipramine, for the treatment of obsessive compulsive disorder (sponsored by Ciba-Geigy Pharmaceuticals of Summit, NJ);
- Trimetrexate, for treating *P. carinii pneumonia* in certain AIDS patients (National Institute of Allergy and Infectious Diseases);
- Cytomegalovirus (CMV) immune globulin for attenuation of primary CMV infection associated with kidney transplantation (Massachusetts Department of Public Health and currently available only in Massachusetts and Maine);
- Ifosfamide and mesna for germ cell cancer when chemotherapy has failed (National Cancer Institute).

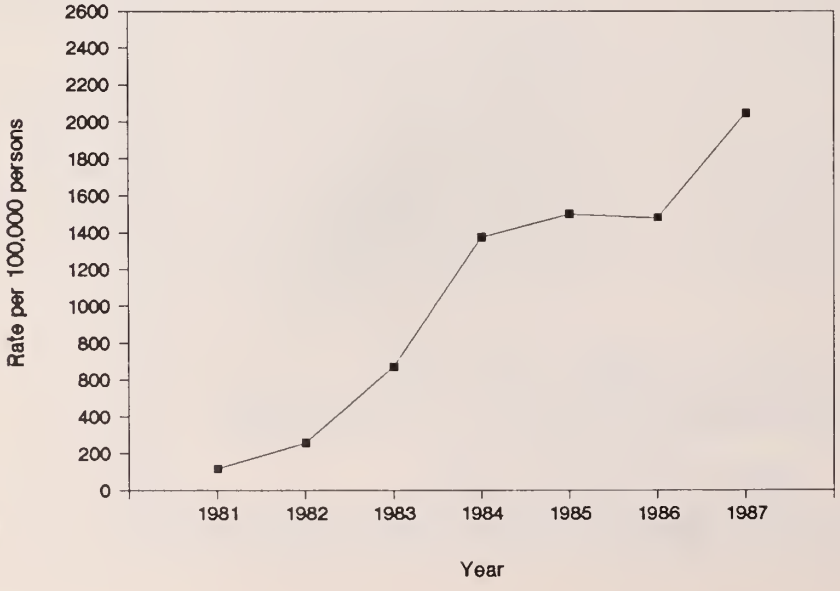
To obtain a drug for a treatment IND, a physician should contact the company or agency sponsoring the drug or, in some cases, the FDA directly. Detailed information is included in the *FDA Drug Bulletin* for August 1988 (Volume 18, Number 2).■

Day care may be linked to giardiasis increase

Cases of giardiasis reported to the state Division of Health have increased dramatically in Wisconsin during the past seven years—from 116 in 1981 to more than 2,000 in 1987 (see Fig 1)—according to a report recently issued by the Department of Health and Social Services. The *Wisconsin Epidemiology Bulletin* also says that the number of counties reporting cases of giardiasis increased as well, from 25 in 1981 to 67 in 1987.

In 1987, more than half the cases occurred in months of July through October, with August being the peak month. One third of cases were in children under age 5, and nearly one fourth of all cases occurred in those who either attended a day care center or had a family member who attended or worked in a day care center.

Figure 1: Reported Giardiasis Incidence – Wisconsin, 1981–1987



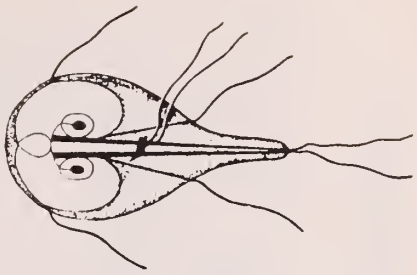
Giardiasis is caused by *Giardia lamblia* (see Fig 2), an intestinal protozoan parasite, and the most frequently reported enteric pathogen in Wisconsin. It is usually transmitted through personal contact, but can contracted by consuming contaminated food or water. The Division of Health report says the ingestion of as few as ten *G. lamblia* cysts can cause infection, and cysts can remain viable outside a human host for up to three months in a moist environment. Symptoms of giardiasis include diarrhea, steatorrhea, abdominal cramping, bloating, fatigue, and weight loss.

Reasons for the increase in reported giardiasis cases are not fully understood, the report says. One possible explanation is that *G. lamblia* infection is becoming increasingly endemic in parts of the state. In endemic giardiasis a large asymptomatic population serves as a reservoir for the

parasite. The study also speculates that day care facilities may serve as a transmission pool. Other reasons cited by the study include greater awareness in the state about the disease, increased screening, and enhanced surveillance and follow-up of infections. The report also says infection from contaminated water may explain the increase in disease during the summer and early fall, when people are more likely to travel and camp in areas served by untreated surface water.

The prevention and control of giardiasis are difficult, according to the study, particularly if the disease is endemic in a population. It recommends that efforts focus on preventing outbreaks from contaminated food and water and controlling transmission in high risk settings such as day care centers. The prevention of food and waterborne transmission of *G. lamblia* involves identifying and treating infected food handlers and ensuring a safe drinking water supply, the report says.

The *Wisconsin Epidemiology Bulletin,* which contains a full report on the giardiasis study, is available from the Division of Health, Department of Health and Social Services, 1 W Wilson St, PO Box 309, Madison, WI 53701-0309. ■



Giardia lamblia (approximately X1100)

Medicare: questions and answers

Q. I was recently audited by Medicare and have a number of questions about the review. What are the signature requirements on progress notes for Medicare?

A. If you are audited, Medicare will review progress notes to determine the level of care and to be sure the physician saw the patient. If progress notes are not signed, Medicare may consider the service never rendered. Hospital notes and nursing home notes must always be signed. Solo practicing physicians do not need to sign office notes.

Multiple physicians practicing in an office must sign their patient notes. Signatures should include your full name. Initials do not meet Medicare's signature requirements. Medicare will accept a stamp of your signature, but the SMS encourages physicians to review and sign all progress notes.

Q. If the Medicare analysts cannot read my hand writing on my progress notes, will this affect my audit?

A. If Medicare's analysts cannot read your handwriting, the service may be reduced to the lowest level of care or denied. You may send a typed copy of the progress notes along with a copy of the original notes to Medicare.

Q. If I was audited and Medicare reviewed my notes, will it let me know if I could be billing a higher level of care based on the documentation found in my progress notes?

A. Medicare reviews physicians because their billing practice exceeds practice norms. The analysts review progress notes to determine if they correspond with the level of care you billed on the claim. If an error is found in reimbursement of the procedure code billed on the claim form, Medicare will make an additional payment or reduce the overpayment.

Q. One of my patients recently had surgery performed by another physician and I performed the follow up care. How should I bill for the post-operative care to receive reimbursement from Medicare?

A. The surgeon must submit his or her claim using a 54 modifier to let Medicare know that he or she performed the surgery only. When you bill for the post-operative care, use the 55 modifier to let Medicare know you are performing the post-operative care only. If the surgeon does not use the 54 modifier, Medicare will reimburse the surgeon for the global fee and your claim will be denied.

Q. Medicare reimburses most surgeries based on a global fee. How do I determine the number of post-operative days Medicare includes in the global surgical fee?

A. Each surgery has a different number of pre-operative and post-operative days included in the global fee based on the procedure performed. WPS-Medicare just released a listing to the SMS of all surgeries which are reimbursed based on a global fee. It lists the number of pre-operative and post-operative days which are considered part of the global fee.The SMS will be printing this listing for physician offices soon. Information on how to request this

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listing, and the cost, will appear in Medigram.

Q. Do Physician Assistants need to meet "incident to" guidelines?

A. First, let's define "incident to" guidelines. "Incident to" a physician's professional service means the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness. For services performed by non-physician personnel to be considered "incident to" a physician's service, the physician must be actively engaged in the treatment of the patient and not merely acting in an administrative or consulting capacity. The service must be the type ordinarily furnished in a doctor's office. The non-physician must be under the direct supervision and be an employee of the treating physician, and the treating physician must bill for the work performed by the non-physician personnel.

When physician assistants perform services in an office, they must meet these requirements. Services performed by a physician assistant in the hospital, skilled nursing facility, intermediate care facility or assisting at surgery (wherever the surgery is performed) are also covered by Medicare.

Physician assistants covered under "incident to" cannot receive direct Medicare reimbursement. Medicare reimbursement is made to the employer of the physician assistant who must bill for the services. Billing requirements for physician assistant can be found in the November 1987 *Communique*.

Beginning Jan 1, 1989, physician assistants performing services in a designated health manpower shortage area (HMSA) will not need to meet "incident to" guidelines for office seminars. More information will be given in upcoming issues of the Medigram. ■

Loss prevention corner

Wisconsin's statutes of limitation

Wisconsin's medical malpractice statutes of limitation are designed to give potential defendants a right of repose after these periods of limitation run their entirety. The current medical malpractice statutes of limitation, Wis Stat §893.55 and §893.56, are unusual as they are specific concerning a discovery period and time the claim for relief accrues. These specific discovery and accrual features are important in light of recent Wisconsin Supreme Court decisions that have extended the time for plaintiffs to bring claims under other tort theories and will be discussed later in this summary.

Statutory provisions

A: The sane, adult plaintiff. The medical malpractice statute of limitations as provided by Wis Stat §893.55 requires an adult, sane plaintiff to bring an action to recover damages for injuries within the later of:

1. 3 years from the date of the injury; or
2. 1 year from the date the injury was discovered, or in the exercise of reasonable diligence should have been discovered, but no more than 5 years from the date of the act or omission; or
3. if a health care provider conceals from a patient a prior act or omission which has resulted in injury to the patient, within 1 year from the date the patient discovers or in the exercise of reasonable diligence should have discovered the concealment; or
4. when a foreign object without any therapeutic or diagnostic purpose or effect has been left in a patient's body, within 1 year after the patient is aware or in the exercise of reasonable care, should have been aware of the presence of the object.

The statute leaves the time period open concerning those instances where a patient alleges concealment or the discovery of a non-therapeutic foreign object, with the limit for the patient to exercise "reasonable diligence" or "reasonable care" in discovering this injurious condition. As a consequence, in those specific cases where the claim is more than 5 years old, the defendant would need to argue that the plaintiff did not exercise reasonable diligence or care in discovering this injury to have the claim dismissed as being outside the statute of limitations.

B: The adult, insane or imprisoned plaintiff. As a necessary cross reference to Wis Stat §893.55, Wis Stat §893.16 provides an extension for bringing a claim to adults under disability because of insanity or imprisonment for a criminal charge. This disability must have existed at the time injury occurred or claim arises. Under this statute, the plaintiff is given 2 years to bring a claim after the disability ceases, but no more than a total of 5 years extension for this disability. This extension is in addition to the above outlined time for adult plaintiffs to bring a claim for relief. In the simplest case, that is, an alleged injury that fits *A* 1., the disabled adult has up to 8 years to bring a claim—3 years plus 5 years extension for the disability.

C: The minor plaintiff, not under another disability. Actions brought by minors, defined by law as individuals under age 18, are governed by Wis Stat §893.56. This statute states that minors not under disability by reason of insanity, developmental disability or imprisonment shall bring an action within the later of: (1) the time limitation under Wis Stat §893.55; or (2) by the time that person reaches the age of 10 years.

Under either provision, the minor's parent, guardian, or other person having custody of the minor brings the

action against the health care provider.

D: The minor plaintiff, under another disability. Wis Stat §893.16, as previously discussed, extends the time for persons under disability at the time the action accrues to 2 years after recovery or a maximum of 5 years. This statute explicitly exempts minority as a disability for the purposes of medical malpractice claims. This provision, however, would apply to minors under another disability, such as insanity or imprisonment.

The question has arisen in other contexts whether developmental disability would come under this section as insanity and therefore limit a developmentally disabled child's ability to bring a claim (through a parent, guardian, or other legally authorized representative) to a maximum 5 years after the expiration of the time limits of Wis Stat §893.56. If developmental disability is not considered a disability as referred to in Wis Stat §893.16, there would appear to be no statute of limitation that would apply to the situation involving a developmentally disabled minor plaintiff.

Wisconsin case law

In addition to the law as codified by the Wisconsin Statutes described above, medical malpractice statutes

of limitations are defined by court made law or case law. Although the language of the statutes seems to be clear, courts have expanded certain terms to broaden the time limits that apply to medical malpractice claims. Two recent Wisconsin Supreme Court decisions are germane to medical malpractice claims and a brief outline of these cases are discussed below.

In the *Kohnke* decision (*Kohnke v St Paul Fire and Marine, et al*, No. 86-0988; June 8, 1988), the court reviewed a medical malpractice claim brought by the plaintiff more than 20 years after the alleged act of malpractice occurred. Although the defendants argued that the statute of limitations under either Wis Stat §893.55 or its predecessor, Wis Stat §330.33, had run out and the defendants had a right to repose, the court found that the old statute applied. The court then stated that its 1986 decision in *Borello v U.S. Oil* explicitly overruled a series of earlier Wisconsin Supreme Court medical malpractice decisions on this issue and, therefore, expanded the statute of limitations for certain medical malpractice claims.

The court restated its earlier decisions in *Borello* and another case, *Hansen v A.H. Robins Co*, that civil tort claims governed by statutes that do not have legislatively created discovery rules (Wis Stat §893.55 creates a limited discovery rule as described in *A* 2. above) accrue when the plaintiff discovers his or her injury. As a non-medical malpractice example, if a plaintiff is rendered sterile allegedly because of an injurious IUD, she would have 3 years under the personal injury statute of limitations after discovering her injury and the causal relationship of the IUD to her injury to bring a claim against the manufacturer. The technical reason for this expansion of the plaintiff's right to redress is that claims might arise at the time of the alleged negligence but do not accrue until the plaintiff discovers the negligence. Wis Stat §893.55 and §893.56 specifically state that the medical malpractice claim must be brought within the stated time after the date of injury, thus affixing the claim's accrual to the time of injury, except for the limited discovery rule also described in these statutes.

In the *Kohnke* case, since the former statute of limitations for medical malpractice claims—Wis Stat §330.33—applied, the plaintiff's claim accrued when he discovered his injury (sterility), and he was given 1 year to file his claim after his discovery. The court did limit old claims brought by plaintiffs applying for this discovery rule by stating that claims accrue on the date the injury is discovered or with reasonable diligence should be discovered. Therefore, just as with Wis Stat §893.55 and §893.56 requirement of reasonable care or diligence, defendants can prevent rejuvenation of old claims by demonstrating that the plaintiffs did not exercise reasonable diligence in discovering their injury.

Kohnke's effect on medical malpractice claims is that alleged negligent acts that occurred before Wis Stat §893.55 and §893.56's enactment, July 1, 1980, but are not discovered until now may be brought under the discovery rule described in *Kohnke*.

In another case (*Robinson v Mount Sinai Medical Center, et al*, No. 84-2301; Oct 4, 1985), the Wisconsin Supreme Court decision concerned the issue of when a medical malpractice claim accrues where successive actors have participated in a continuum of allegedly negligent treatment. Here the court expanded the statutory time limit for the plaintiff to file a malpractice claim to reach otherwise safe defendants based on the last medical treatment date in a series of treatments by different health care providers. This ruling means that physicians who are involved at the onset in the treatment of a patient for a condition that later becomes the subject of a medical malpractice claim can be brought into a malpractice suit even though the statute of limitations has otherwise expired if this treatment was part of a continuum of negligent treatment.

A continuum is defined as a grouping of facts falling into a single unit or occurrence as a lay person would view them. Although the court did pointed out that this continuum must be that of negligent treatment, the continuum of negligent treatment does permit a plaintiff to include

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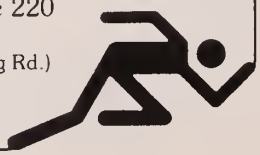

defendants who acted independently of one another and not just defendants who acted "in concert," or jointly.

Although there has not been any apparent increase in malpractice claims that might otherwise be stale under the continuum of negligent treatment rule defined in *Robinson v Mt Sinai Medical Center*, it is not difficult to imagine situations to which this rule could be applied. Again, the real effect of this decision is to expand without definite limitation the otherwise concrete limitations imposed by Wis Stat §893.55 and §893.56.

Summary

The time limitations on medical malpractice claims are defined by both statute and case law, but perhaps without the clarity desired by those subject to them. The definitional problem stems from the competing interests of the plaintiff's right to redress and the defendant's right to repose. The legislature has assisted in defining these rights by the enactment of the current statutes, but the courts have subsequently expanded these limits out of a perceived need to protect the interests of potential plaintiffs.

Physicians need to be aware of the flexibility involved in medical malpractice statute of limitations and consider the possibility that a claim might still be open to judicial review before classifying a case closed.■

The cost of violence

Intentional injury accounts for an increasing proportion of trauma cases in the United States and an increasing economic burden on treatment centers, according to a report in the July *Archives of Surgery*. Seventeen percent of the 2,451 trauma patients studied for the report were admitted to Seattle's Harborview Medical Center for nonaccidental injuries; the majority were severely injured. Hospital charges averaged $13,000 per patient, with 75% requiring governmental funding for medical care. Six months after the authors finished their review, only two thirds of all expenditures had been reimbursed.■

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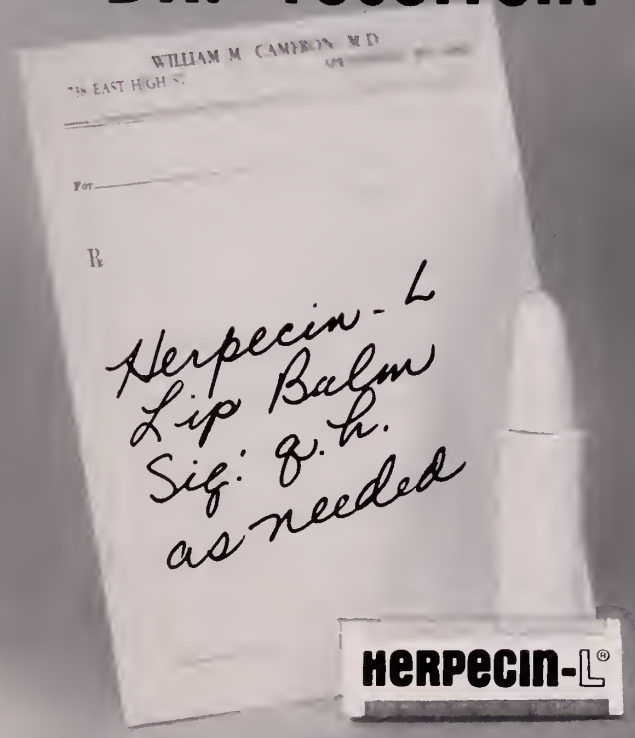

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SMS Past president advises national rural health council

Kenneth M. Viste, Jr, MD, of Oshkosh, testified before the National Advisory Council on Rural Health in Washington, DC, on Sept 19, 1988. Dr Viste offered his testimony as the immediate past president of the SMS and former chairman of the SMS Task Force on Rural Health. The following were his remarks.

Members of the council: My name is Ken Viste, Jr, MD. I am a physician who grew up in rural Wisconsin and am currently in the practice of neurology in Oshkosh, Wisconsin. As an active member in organized medicine, I wear a number of different hats and am here today as the immediate past president of the State Medical Society of Wisconsin (SMS). The Society represents approximately 80% of the physicians in practice in the state of Wisconsin.

From a state's perspective, we are pleased that the federal government has formalized its commitment to rural health issues through the creation of the Office of Rural Health and the National Advisory Council on Rural Health. Today, we appreciate the opportunity to share with you some of our experiences regarding the challenges of rural practice in Wisconsin.

One of my prime objectives during my term as president of the Society last year was to create a Task Force on Rural Health. The task force looked specifically at access to rural health care and developed several recommendations aimed at improving the delivery of health care to rural areas. Appointed to the task force were seven physicians with rural practices, one physician from an urban area and representatives of the hospital community, aging groups and the state health agency. As chairman of the task force, and as one who is deeply concerned about health care in rural Wisconsin, I take special pride in what we accomplished in such a short period. We have not answered all of the questions, but we have pointed to the direction that future efforts must go to address the challenges, problems and concerns confronting rural health care in Wisconsin which in many ways is a microcosm.

One of our first activities as task force members was to poll physicians whose practices can be termed as predominantly rural in character. The results of our poll confirmed our suspicions. They also gave us direction and helped to set priorities for our work.

Kenneth M. Viste, Jr, MD

Overall, the survey results reflected the concerns of our rural members and the strong dedication and spirit which they have given to our profession.

One physician, for example, wrote on the problem of physician recruitment, urging rural rotations for medical residents. He spoke of students who go through their training "without ever experiencing the practice of medicine without a CT scanner or cardiologist down the hall." This letter described the advantages of a rural practice, namely, more physician independence, better patient relationships and appreciation, and "the special pleasure in filling a void in medical care rather than fighting for part of the market." The physician's poignant remarks reflect the kind of positive image-building that rural health care needs to attract new faces and new commitments.

In the report before you, we have outlined 32 recommendations aimed at improving the delivery of medical care in rural Wisconsin. The recommendations focus on three areas: physician manpower, hospital and physician payment differentials and health care delivery as a rural development strategy. Very briefly I'd like to discuss our findings in these areas.

Like many areas of the country, Wisconsin desperately needs primary care physicians willing to seek rural practices. In fact, 71% of the physicians responding to the task force poll indicated they or their groups are planning to recruit more physicians, primarily family physicians.

In addition, New Physicians for Wisconsin, a physician placement service sponsored by the University of Wisconsin's Department of Professional and Community Development and the Department of Family Medicine and Practice, is actively recruiting family physicians in 75 Wisconsin communities.

To improve physician recruitment and retention in rural areas, the task force recommended, among other things, the development of a rural primary care curriculum for medical students; a state loan forgiveness program for physicians who practice in shortage areas, similar to the National Health Services Corps; establishment of an area health education center; and a rural health support system to provide continuing medical education opportunities, office management assistance, and physician back-up support.

Another major set of task force recommendations was aimed at seeking a more equitable and realistic payment structure for rural physicians and hospitals under Medicare. Medicare physician charge data reviewed by the task force showed differences of up to 48% between urban and rural providers. Physicians who responded to the rural health survey also confirmed that geographic variation in physician reimbursement is a chief concern. Although it is often assumed that practice overhead costs for rural physicians are lower, in reality this is not the case. Rural physicians, for example, report their labor costs to be similar to their urban colleagues, and are often competing with urban offices for trained personnel. In terms of travel time and transportation, office overhead costs are often greater for rural physicians.

Similar disparities between urban and rural hospitals under Medicare's Prospective Payment System have already been well publicized. Current Medicare reimbursement policies, in fact, may be at least as effective in closing rural hospitals as the Hill-Burton Act was in constructing these same facilities.

Task force recommendations pertaining to payment disparities call for the development of a public information campaign aimed at further educating state and federal lawmakers to the problems experienced by rural health care providers and their patients.

Making problems worse, however, are the higher Medicare patient populations cared for by rural hospitals and physicians. Demographic data reviewed by the task force showed that counties with lower population densities had higher percentages of elderly, as well as lower median family incomes.

Across the country, rural populations are aging faster. Rural populations also tend to have larger percentages of uninsured and underinsured due to large numbers of rural workers who are self-employed, seasonally employed, or working in lower paying, full-time jobs.

These issues and affordability concerns were also reflected by the task force's survey results.

Nearly three fourths of the physicians surveyed said they have seen a growth in the number of patients during the past 5 years who rely on government-subsidized health care. More than 60% noted marked increases in the amount of write-offs for uncompensated care during this time. About the same number of physicians indicated either no change or a decrease in their incomes since 1982, despite working more hours in their practices. It is no small wonder that those responding to our survey viewed geographic variations in physician reimbursements as one of their chief concerns, second only to medical liability.

While payment disparities are important, the task force members also agreed that long-term solutions to rural health care concerns must be viewed in a far broader context in relation to rural development as a whole.

Rural hospitals are dependent upon strong community support and continued growth in the local economy. Likewise, these same local economies are dependent upon the continued presence of the community hospital and a viable rural health care delivery system.

The small community hospital is often the largest employer in the area—the heart of the local health care delivery system, and a major plus for attracting new physicians, as well as new business and industry to the area. People need to be reminded of this important relationship.

Although the Task Force on Rural Health urged steps to encourage more community-based approaches to rural health care delivery concerns, we have also recommended initiatives that state government could take to assist these local efforts. One is to develop options to strengthen capital financing help for health care facilities in chronically underserved areas. The task force also recommended a state planning grant program for pilot projects in underserved rural areas for the purpose of creating cooperative health care services programs and rural provider networks that would offer comprehensive primary care services to underserved populations.

In speaking with our colleagues who practice in other rural areas of the country, the Society realizes that our experiences are not unique to Wisconsin. It is our hope, however, that sharing our observations will shed some

Continued on page 38

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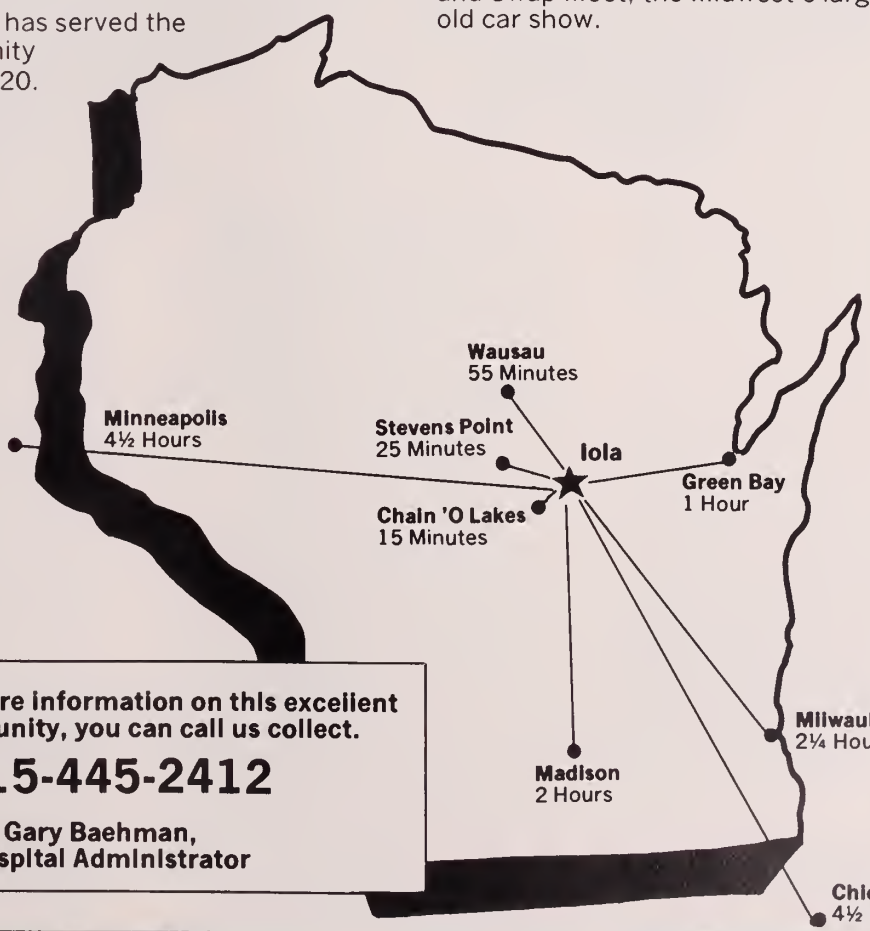

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Ask for Gary Baehman, Iola Hospital Administrator

Continued from page 36

light on these very difficult problems and help to ensure the delivery of quality medical care to rural America.

We are encouraged by the efforts by the National Rural Health Association, the National Association of Community Health Centers, the American Medical Association, many state organizations and now the Office of Rural Health and its advisory council that have helped to give rural health care issues a new prominence on the agendas of state and federal lawmakers. While the work of the SMS Task Force on Rural Health is completed, it will be up to each of us to ensure that rural health care and rural development issues continue to receive the attention they truly deserve. I believe that we have the ability and the resources to be a model in this endeavor if we continue to work together.

I'd be happy to answer any questions members of the council may have. Thank you for your time.■

AMA Physician recognition awards

Qualifying physicians can now receive one- and two-year Physician Recognition Award certificates from the AMA. Previously, certificates were issued for only three years. According to AMA officials, the change was made to accommodate physicians who must report continuing medical education credits to various licensing boards, many of which operate on a two-year cycle.

Effective Sept 1, physicians having 50 hours of continuing medical education, including 20 hours of Category 1 credits, will be eligible for a one-year certificate. To received a two-year certificate, a physician must report 100 hours of education, including 40 hours of Category 1. The requirements for the three-year certificate remain unchanged at 150 hours of continuing medical education.

The Physician Recognition Awards certificate will be revised to indicate the date it was issued and when it expires. The application fee continues to be $10 for AMA members and $30 for nonmembers.

For more information on the new requirements, or to receive an application, contact the Department of Physician Credentials and Qualifications, American Medical Association, PO Box 10014, Chicago, IL, 60610-0014; or call 312-645-4665.■

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

July 1988

*Baldauf, Mary C., Marshfield
*Barthel, Larry J., Durand
*Bhore, Jayawant N., Milwaukee
*Blankenship, James C., Marshfield
*Blau, Edward B., Marshfield
Boehme, Larry R., Hillsboro
*Boys-Smith, John W., Marshfield
*Brasington, Richard D., Marshfield
*Carlson, Robert A., Marshfield
*Chen, Jane E., Marshfield
*Choucair, Ali K., Marshfield
*Chu, Felix W., Fond du Lac
*De Mott, Robert K., Green Bay
*Drexler, Lawrence J., Marshfield
*Edelstein, Barry B., Marshfield
*Erickson, Scott S., Marshfield
*Fetzer, Frederick P., Marshfield
*Gallant, Thomas E., Marshfield
*Gohdes, Paul N., Neenah
*Goldman, Ian Lee, Marshfield
*Gottlieb, Victor, Marshfield
*Gross, Jody R., Marshfield
*Hartert, James E., Marshfield
Hecht, Rudolph C., Madison
*Hoehn, James L., Marshfield
*Holt, James J, Marshfield
*Keppen, Bruce W., Marshfield
*Krall, Edward J., Marshfield
*Meyer, James A., Marshfield
*Miller, Lawrence H., Waupun
Pearlman, Mary, Madison
*Quackenbush, Steven R., Woodruff
*Ramos, Teodoro M., Ripon
*Reding, Douglas J, Marshfield
*Sajjad, Syed M., Marshfield
Sell, Patricia A., Marshfield
Sheppard, Joseph E., Marshfield
*So, Elson L., Marshfield
Steinmetz, Timothy F., Stanley
*Stueland, Dean T., Marshfield
*Swain, Geoffrey R., Milwaukee
*Swamy, Pandy G., Marshfield
*Tipping, Stuart J., Marshfield
*Wahls, Terry L., Marshfield
*Witkowsky, Roman B., Marshfield
*Zoch, Thomas W., Marshfield■

August 1988

Almquist, Adrian, Marshfield
Anderson, Pamela E., Milwaukee
*Beatty, Peter A., Sheboygan
*Berridge, Frank E., Milwaukee
*Brandeland, Gary P., Eau Claire
*Dernlan, Robert L., Manitowoc
*Ives, Donald G., Whitefish Bay
*Jacobsen, F. Stig, Marshfield
*Klasinski, Clarence A., Stevens Point
*Knauf, James W., Chilton
*Lamont, Frederick J., Green Bay
Mieler, William F., Waukesha
*Miller, Thomas O., Wausau
Neu, Steven E., Green Bay
Pulito, Frank J., Milwaukee
*Schulgit, Ronald E., Racine
*Stewart, Richard D., Racine
Thomason, Jessica L., Milwaukee
Weiss, Steven D., Eau Claire
*Wilson, Janet A., Wisconsin Rapids
*Winther, Jon N., New London

Correction: In the September 1988 edition of the *WMJ*, the AMA awards listing for June 1988 incorrectly identified Dr R. V. Reddy, of Neillsville, as Venkata R. Reganti and as a nonmember of the SMS. Dr Reddy is a member of the SMS and did earn an AMA Physician Recognition Award in June.■

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Summary
Consult the package literature for prescribing information.

Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae, Haemophilus influenzae,* and *Streptococcus pyogenes* (group A β-hemolytic streptococci)
Contraindication: Known allergy to cephalosporins
Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.
Administer cautiously to allergic patients.
Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.
Precautions:
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)
Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea) 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever). 1.5%, usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%, genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology
- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis, elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly).

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Second annual *WMJ* writing contest

Contestants
- medical students enrolled in either of Wisconsin's medical schools
- residents actively training in Wisconsin

Awards
- one student; one resident
- recognition certificate and $500
- publication of paper in the *Wisconsin Medical Journal*
- presentation at the 1989 SMS Annual Meeting

Rules
- subject matter must fall within the parameters of scientific medicine: clinical, case report, research and review
- paper must be original, unpublished, and credited to one author (although multiple authors may be listed)
- limited to 10 pages, typewritten, double-spaced, with 1-inch margins
- illustrations are encouraged, but must be included in the 10-page limit

Criteria
- *scientific merit:* research methods, data analysis, subject or patient population selection, control of variables, and literature analysis
- *applicability:* usefulness of results to private practitioners, academicians, or researchers
- *content:* depth of analysis, continuity of discussion supporting the main thesis, and feasibility of conclusions
- *innovation:* uniqueness of idea, creativity, improvement of existing techniques, previously undiscovered data, or advancement of basic understanding
- *style:* organization and clarity of writing

Deadline
- Entries must be received by the *Wisconsin Medical Journal* no later than Jan 31, 1989: PO Box 1109, Madison, WI 53701.

1988 Winners
- *Medicine on television: fact, fiction, or both?* by Lance P. Longo, Medical College of Wisconsin
- *Peritoneovenous shunting for malignant ascites* by Gwen D. Martin, MD, a surgical resident at the Gundersen Clinic in La Crosse■

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BRIEF SUMMARY

CONTRAINDICATIONS
There are no known contraindications to the use of sucralfate.

PRECAUTIONS
Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that simultaneous administration of CARAFATE (sucralfate) with tetracycline, phenytoin, digoxin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The clinical significance of these animal studies is yet to be defined. However, because of the potential of CARAFATE to alter the absorption of some drugs from the gastrointestinal tract, the separate administration of CARAFATE from that of other agents should be considered when alterations in bioavailability are felt to be critical for concomitantly administered drugs.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). There was no evidence of drug-related tumorigenicity. A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies were not conducted.

Pregnancy: Teratogenic effects. Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%).

Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

OVERDOSAGE
There is no experience in humans with overdosage. Acute oral toxicity studies in animals, however, using doses up to 12 gm/kg body weight, could not find a lethal dose. Risks associated with overdosage should, therefore, be minimal.

DOSAGE AND ADMINISTRATION
The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED
CARAFATE (sucralfate) 1-gm tablets are supplied in bottles of 100 (NDC 0088-1712-47) and in Unit Dose Identification Paks of 100 (NDC 0088- 1712-49). Light pink scored oblong tablets are embossed with CARAFATE on one side and 1712 bracketed by C's on the other. Issued 1/87

Reference:
1. Eliakim R, Ophir M, Rachmilewitz D: *J Clin Gastroenterol* 1987;9(4):395-399.

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Physician briefs

The day after the Wisconsin primary election, Sept 14, the Medical Society of Milwaukee County hosted a political picnic at Serb Hall in Milwaukee. Both party chairs were present to discuss the primary results and answer questions about their party's expectations for the 1988 election year. Dr Timothy Flaherty, chairman of WISPAC, moderated the discussion. Pictured above: Sen Donald Stitt, Republican Party chair (l), Timothy Flaherty, MD, WISPAC chair (c), and Suellen Albrecht, Democratic Party chair (r).

Edward H. Regehr, MD,* recently joined the Omro Family Health Clinic in Omro and Mercy Medical Center in Oshkosh. A general practitioner, Dr Regehr received his degree from the University of Manitoba in Winnipeg and served an internship at Winnipeg General Hospital.

Sigurd B. Gundersen, III, MD, recently joined the staff of Gundersen Clinic in La Crosse. A general surgeon, Dr Gundersen received his medical degree from Northwestern University in Evanston, Ill. He completed residencies at St Joseph's Hospital in Milwaukee and the University of New Mexico Hospitals in Albuquerque.

Kenneth M. Viste, Jr, MD,* of Oshkosh, received the 1988 Dr H. Conrad Hoyer Award for Leadership from the Coalition of Wisconsin Aging Groups at its annual meeting in September. A neurologist, Dr Viste is the immediate past president of the SMS and was honored for his efforts on behalf of PartnerCare.

Frederick B. Klaas, MD,* of Ellsworth, recently retired after 41 years of medical practice. He received his medical degree from Marquette University School of Medicine in Milwaukee and served as a captain in the US Army Medical Corps before opening a clinic in Ellsworth in 1947.

Eric A. Nimmo, MD,* a family practitioner, recently joined the staff of the Marshfield Clinic, Ladysmith Center. He received his degree from the Medical College of Wisconsin and completed a residency at St Michael Hospital in Milwaukee. He previously was in private practice in Cuba City.

Lloyd H. Arnold, MD, recently joined the medical staff at St Michael's Hospital in Stevens Point. A pathologist, Dr Arnold received his degree from the Medical College of Wisconsin and completed a residency at the school's affiliated hospitals in Milwaukee.

Mark Sontag, MD,* recently joined the staff of Eau Claire Anesthesiologists, Ltd. Dr Sontag graduated from the University of Minnesota Medical School and served an internship at Loyola University Medical Center in Chicago. He completed a residency at the University of Minnesota in Minneapolis.

Jeffrey McGuire, MD, recently joined the staff of Medical Associates of Fort Atkinson. Dr McGuire received his medical degree from the University of Wisconsin Medical School and completed a residency in family practice at Fox Valley Residency Center in Appleton.

Mark W. Asplund, MD,* recently joined the Wausau Medical Center. Dr Asplund graduated from the University of Wisconsin Medical School and completed a residency in general surgery at Methodist Medical Center in Des Moines, Iowa.

Michael Krco, MD, recently joined the medical staff at Milwaukee Medical Clinic. A urologist, Dr Krco graduated from the University of Illinois College of Medicine in Chicago and completed an internship at Cook County Hospital. He completed a residency at Milwaukee County General Hospital and Woods Veterans Administration Hospital in Milwaukee.

Thomas A. Wolfe, MD,* recently joined the General Clinic in Antigo. Dr Wolfe received his degree from Indiana University School of Medicine and recently completed a fellowship in high-risk obstetrics and gynecology in Spokane, Wash. He also has served as a staff physician at Westside Immediate Medical Care Center and an emergency room physician at Southwest Michigan Emergency Services, both in Kalamazoo.

Carl B. Weston, MD, was recently named medical director of Meriter-Madison General Hospital in Madison, replacing Gordon Davenport, MD, who will retire in December. A Madison native, Dr Weston previously was medical director of Health Care, Inc, in New Haven, Conn. He graduated from the University of Pennsylvania Medical School and completed a residency at University Hospitals in Madison.

Scott D. Brunk, MD,* has joined Black River Memorial Hospital in Black River Falls as an emergency room physician. Dr Brunk received

his degree from the University of Iowa Medical School and completed a residency at the St Francis-Mayo Clinic Family Practice Program in La Crosse.

Bruce C. Rhoades, MD,* of Wausau, recently joined Marshfield Clinic. Dr Rhoades previously was director of psychiatry for North Central Health Care Facilities. He graduated from the University of Nebraska College of Medicine in Omaha and completed a residency at Nebraska Institute, also in Omaha.

Raymond L. Hansen, MD,* recently retired from Marshfield Clinic after nearly 21 years on the clinic's staff. A pediatric allergist-immunologist, Dr Hansen graduated from the University of Wisconsin Medical School and served an internship at St Joseph's Hospital in Marshfield. He completed a residency at the Mayo Graduate School of Medicine in Rochester, Minn. Dr Hansen served as chief of staff at St Joseph's Hospital for the past three years.

Charles Rathjen, MD, recently joined Waupaca Family Medicine and Riverside Community Memorial Hospital. Dr Rathjen received his degree from the University of Nebraska Medical Center and completed a residency in family practice at the University of Wisconsin and Riverside Hospital.

Malini Sridharan, MD,* recently joined Merrill Medical Associates. A family practice physician, Dr Sridharan graduated from Mysore Medical College in India. In 1987 she received the Physician's Recognition Award from the American Medical Association.

James H. Kelly, MD,* recently joined the medical staff of the Krohn Clinic and the Black River Memorial Hospital in Black River Falls. Dr Kelley received his medical degree from the University of Bologna in Bologna, Italy, and completed a residency at the University of Wisconsin–Department of Family Medicine and Practice, Eau Claire Family Medicine Residency Program.■

SMS Membership roster available

The 1988–89 SMS membership roster, recently published in the August issue of the *Wisconsin Medical Journal*, is available from the SMS at a cost of $25. For more information, contact the SMS Division of Communications at 1-800-362-9080 or 608-257-6781.■

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News highlights

The Wisconsin Association of Senior Physicians held its annual meeting Sept 10 in Madison and elected the following officers: Vincent W. Nordholm, MD,* of Stoughton, president; Ann Bardeen-Henschel, MD,* of Oconomowoc, president elect; and Russell P. Sinaiko, MD,* of Madison, secretary-treasurer.

Gundersen-Farrell Clinic of Prairie du Chien recently announced that three new physicians have joined the medical staff. They are: Walter R. Boisvert, MD, Marilu Bintz, MD, and Ren R. Whitaker, MD. Dr Boisvert received his degree from the University of Wisconsin Medical School and completed a residency in the UW Family Practice Program, St Mary's Hospital Medical Center in Madison. Dr Bintz, a general surgeon, received her medical degree from Indiana University in Bloomington and recently completed a residency at Gundersen Clinic and Lutheran Hospital in La Crosse. Dr Whitaker, a family practice specialist, received his medical degree from the University of Washington in Seattle and served an internship at the US Public Health Service Marine Hospital in New Orleans. He completed a residency at the US Public Health Indian Hospital in Gallup, NM.

The Berlin Hospital Association recently named Craig W.C. Schmidt president and chief executive officer. Schmidt most recently served as chief operating officer at Valley View Medical Center in Plymouth. In his new position he will supervise the operation of the Berlin Memorial Hospital and Juliette Manor.

St Vincent Hospital in DePere recently named Robert Bartingale assistant administrator. He previously served as vice president of Sacred Heart Hospital in Cumberland, MD.

The Marshfield Medical Research Foundation has been awarded a grant of $828,851 by the Robert Wood Johnson Foundation of Princeton, NY, to participate in a study on

the outcomes of various treatments for critically ill patients. Founded in 1972, the foundation has awarded more than $866 million in grants for health care research, including $10.3 million for projects in Wisconsin.

The Marshfield Clinic recently announced that three new physicians have joined its medical staff. They are Judy L. Bardole, MD,* a general surgeon; Todd D. Earnhart, MD, an internal medicine specialist; and Mary M. Gallenberg, MD, an oncologist. Dr Bardole recently completed a residency in Marshfield. She received her degree from the University of Iowa College of Medicine in Iowa City. Dr Earnhart received his degree from the University of Minnesota Medicine School in Minneapolis and completed a residency at University of Minnesota Affiliated Hospitals. Dr Gallenberg received her degree from the University of Wisconsin Medical School and recently completed postgraduate training at Mayo Graduate School of Medicine in Rochester.

Southwest Health Center in Platteville recently elected Paul Groben, DO, president. John A. Mackenzie, MD,* was chosen vice president and Meenakshi Maski, MD,* secretary-treasurer.■

Specialty society news

The **Wisconsin Society of Internal Medicine,** at its September meeting, presented Kenneth I. Gold, MD, Beloit, with the WSIM's Distinguished Internist Award for 1988.

Dr Gold served as president of WSIM in 1980–1981 and currently serves as the American College of Physicians Liaison Representative (Wisconsin chapter) to the WSIM Council. Dr Gold is a member of the board of directors of the State Medical Society of Wisconsin, chairman of the SMS Commission on Continuing Medical Education, a member of the Ad Hoc Committee on Young Physicians, and also is an editorial associate of the *Wisconsin Medical Journal.*

Also at the meeting, Philip J. Dougherty, MD, Menomonee Falls, was the 1988 recipient of the Addis Costello Internist of the Year Award. Dr Dougherty served as president of WSIM in 1983–1984, and also served as a member of the council from 1976–1984.■

Philip J. Dougherty, MD

Kenneth I. Gold, MD

The **Wisconsin Society of Internal Medicine** recently held a joint meeting with the **Wisconsin Chapter of the American College of Physicians** in Milwaukee. Edmund Becker, PhD, project director of the Harvard Relative Value Scale Study, presented the first annual Russell Quirk Memorial Lecture. Dr Becker's talk was entitled "Relatively Speaking: The Resource-Based Relative Value Scale" (RBRVS). The topic covered the latest developments and recommendations concerning the RBRVS study which was commissioned by Congress in 1986 to examine Medicare reimbursement patterns for physicians and to suggest reforms. Dr Becker has been Project Director of the RBRVS Study since its inception in 1986. He also is a research associate in the Department of Health Policy and Management at the Harvard School of Public Health.

The **Wisconsin Allergy Society** is spearheading the organization of a statewide chapter of the Asthma and Allergy Foundation, according to Robert Bush, MD, president of the society. The role of the foundation in Wisconsin would be to bring the programs and services of the national organization to the state's asthma and allergy victims. Dr Bush said that the first efforts of the Wisconsin Chapter will be in the area of patient and public education. He urged that anyone with a question about asthma and allergies to call 1-800-822-2762 or write AAFA Wisconsin Chapter, 611 E Wells St, Milwaukee, WI 53202.

County society news

Brown. Thirty members and guests were present at the September meeting of the Brown County Medical Society. A paper was presented and discussed entitled "Radon: Is it a health hazard?" Nine new members were approved for membership: John R. Boardman, MD,* Richard L. Erdman, MD,* Joseph L. Hodgson, MD,* Michael E. Phillips, MD,* Kevin P. Rosteing, MD,* Robert C. Zimmerman, MD,* Amy K. Schueckler, MD,* Luke T. Warpinski, MD,* and Charles A. La Roque, MD.*

Rusk. Richard E. Dart, MD,* from the Department of Nephrology and Hypertension at the Marshfield Clinic, presented a paper entitled "The role of the calcium channel blockers in meeting the special needs of the patient," at the April meeting of the Rusk County Medical Society. Joseph S. Bachir, MD,* of Ladysmith, was named a trustee to the Charitable, Educational and Scientific Foundation of the SMS and will serve for three years. Also Ms Mary Fleming, dean of women at Mount Senario College, spoke on "Images of women in mythology."

La Crosse. The following membership applications were approved at the September executive committee meeting of the La Cross County Medical Society: Carol M. Rosckowff, MD,* Michael J. O'Brien, MD,* Andrew D. Ta, MD,* Jamel G. Wilde, MD,* John J. Kirkpatrick, MD,* Mark E. McConnell, MD,* Edward Cardona, MD,* Daniel B. Lange, MD,* Karl N. Krecke, MD,* Thomas J. Grau, MD,* and Loghman Zaiim, MD.* Other business included the appointments of David Lee Nelson, MD,* Edward R. Winga, MD,* and Paul H. Steingraeber, MD,* as the Nominating Committee for new officers of the society. Gary L. Bryant, MD,* is the new representative of the county society to the Young Physician Section of the SMS, replacing Michael H. Mader, MD.*

Winnebago. Fifty-seven members were present at the Winnebago County Medical Society meeting to hear the guest speaker, Stuart Wilson, MD, professor of Surgery at the Medical College of Wisconsin, Milwaukee, speak on hyperparathyroidism. New members approved for membership were: Joseph Rizzo, MD,* Bruce R. Abrams, MD,* James R. Schlais, MD,* Kenneth J. Erdmann, MD,* and David E. Coleman, MD.*

Membership update

The following information is being provided from membership reports and from individual members for updating the 1988 Membership Directory as published in the August 1988 issue of the *Wisconsin Medical Journal*. Because of space limitations, address changes and phone numbers will not be included in this update, although they will be changed in the SMS membership records.

County transfers will be included when processing has been completed by the membership records staff.

Changes in practice specialties (as used by the AMA) and changes in board-certified specialties as listed by the American Board of Specialties (see August 1988 Membership Directory) are included. Practice specialties appear before the slash (/) and board-certified specialties appear after the slash.

Anclam DO, Keith R.
108 S 10th Ave
Sturgeon Bay, WI 54235
GP

Allen MD, Lori Joyce Rens
2548 Kendall Ave
Madison, WI 53705
PTH

Andrews MD, John S.
1523½ Chandler St
Madison, WI 53711

Boardman MD, John R.
2760 Lafayette Drive
Green Bay, WI 54304
EM PD

Buddemeier MD, Kamilla J.
4224 Bagley Parkway
Madison, WI 53705
IM

Castillo Jr, MD, Marcelo E.
4950 N Woodburn
Milwaukee, WI 53217

Chamoy MD, Lewis
2300 N Mayfair Road
Milwaukee, WI 53226

Duquesnoy MD, Rudolf
2315 N Lake Drive
Milwaukee, WI 53211

Erdman MD, Richard L.
225 Colleen Lane
De Pere, WI 54115
EM IM/EM

Frantz MD, John A.
1515 10th St
Monroe, WI 53566
IM/IM

Frantz MD, Mary H.
1515 10th St
Monroe, WI 53566
IM/IM

Glad MD, Richard W.
1313 Fish Hatchery Road
Madison, WI 53715

Heifner MD, William R.
70 Sunrise Court
Madison, WI 53713

Hing MD, Ellen
2315 N Lake Drive
Milwaukee, WI 53211

Hodgson MD, Joseph L.
3319 Amity Court
Green Bay, WI 54301
EM

Holmgren MD, Jeffrey P.
603 E 4th St
Washburn, WI 54891
P

Huggett MD, Thomas D.
43 Craig Ave
Madison, WI 53705
FP/FP

Kemper MD, Charles A.
727 Maple St
PO Box 699
Chippewa Falls, WI 54729

Kneubuhler MD, Hans A.
1515 10th St
Monroe, WI 53566
IM

La Roque MD, Charles A.
310 Sumac Drive
Green Bay, WI 54313
AN

Morud MD, Clair M.
5610 Decatur
Omaha, NE 68104
IM

Phillips MD, Michael E.
4450 Whisper Lane
De Pere, WI 54115
EM/EM

Rosteing MD, Kevin P.
1821 S Webster Ave
Green Bay, WI 54301
IM

Schiedermayer MD, David L.
8701 Watertown
Plank Road
Wauwatosa, WI 53226

Schiffman MD, Jeffrey H.
5534 Medical Circle
Madison, WI 53719
P

Schueckler MD, Amy K.
2126 William Francis
Court
Green Bay, WI 54311
OBG

Sorenson MD, Kay B.
2800 Westhill Drive
Wausau, WI 54401
PD

Stilp II MD, Lyall C.
411 Lincoln St
Neenah, WI 54956

Steinmetz MD, Mark C.
4240 Lumley Road, #2
Madison, WI 53711
RO

Stringham MD, James C.
5015 Sheboygan Ave,
#207
Madison, WI 53705
GS

Warren MD, Scott H.
2101 Beaser Ave
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ORS

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Zahm MD, Dennis L.
5171 Greenview
Clarkston, MI 48016
IM

Zimmerman MD, Robert C.
3509 Hidden Valley
Green Bay, WI 54301
EM/EM

County transfers

(From Wood to Door-Kewaunee)
Barr MD, Craig D.
PO Box 608
Sturgeon Bay, WI 54235

(From La Crosse to Dane)
Waniger MD, Ricky J.
2529 13th Place
La Crosse, WI 54601■

The threat to rural health

The increasing number of rural hospital closings and the trend toward regional specialty hospital services may harm elderly rural residents, according to a report by the National Center for Health Services Research and Health Care Technology Assessment. The Study, conducted in New York state and published in the *Journal of Rural Health*, found that only 18% of rural residents 75 and older traveled beyond the county line to obtain hospital care. Of those under 75, however, 31% traveled outside of their county for treatment. Overall, 29% left the county, two third of them traveling to urban medical centers.

Rural patients also had higher costs in urban hospitals, the study said. Using Medicare's diagnosis-related group system, the report found that costs for rural patients were 20% higher than for their urban counterparts. On a second index, which used disease staging and categorized patients by severity of illness, costs were 8% higher.■

Obituaries

Cornelius A. Natoli, MD

Cornelius A. Natoli, MD, 58, of La Crosse, died Aug 30, 1988, in La Crosse. Born March 4, 1930, in Utica, NY, Dr Natoli graduated from Georgetown University School of Medicine, Washington, DC, and served his internship and residencies at Barnes Hospital in St Louis, Mo. Dr Natoli had a private practice in Salt Lake City from 1961 to 1969, and was on the clinical faculty of the University of Utah College of Medicine. In 1969 he became a member of the Gundersen Clinic in the Department of Urology. He was on the clinic's board of directors and also on several administrative committees. Dr Natoli served as a board member of the SMS from 1977 to 1980 and was an alternate delegate and delegate to the AMA from 1979 to 1987. He had been a member of the SMS Nominating Committee and several SMS Reference Committees. Dr Natoli was a fellow of the American College of Surgeons, a member of the American Urological Association, and the Wisconsin Urological Society. He was a member and past president of the La Crosse County Medical Society, a member of the SMS and the AMA. Surviving are his widow, Marla; a daughter, Anne Calkins, of Baraboo; three sons, Michael, of Minneapolis; Patrick, of Chicago; and Brian, of Sheboygan.

George J. Roncke, MD, 70, of Elm Grove, died Aug 29, 1988, in Milwaukee. Born May 4, 1918 in Milwaukee, Dr Roncke graduated from Marquette University School of Medicine in 1932, and served his internship at Toledo Ohio Mercy Hospital. His residency was completed at the Veterans Administration Hospital in Wood, Wis. Dr Roncke served in World War II in the US Army Medical Corps. An ophthalmologist, Dr Roncke had his medical practice in Milwaukee for 30 years. He was a member of the Medical Society of Milwaukee County, the SMS, and the AMA. Surviving are his widow, Gladys; two daughters, Jan Mooney, of Tucson, Ariz; Barbara Klein, of Pretty Lake; and two sons, David, of Brookfield, and Michael of Rockford, Ill.

Harry E. Schaefer, MD, 65, former Manitowoc physician, died July 8, 1988, in Kingman, Ariz. Born Feb 28, 1923, in Antigo, Dr Schaefer graduated from Marquette University School of Medicine and served his internship at St. Luke's Hospital in Milwaukee. After his internship, Dr Schaefer served in the United States Air Force from 1952 to 1954, during the Korean Conflict. He was one of the cofounders of The Medical Arts Clinic, Manitowoc, retiring from medical practice in 1984. Surviving are his widow, Judith; three children, Harry, of Manitowoc; Craig and Kim of Kingman, Ariz.

Gerhard R. C. Anderson, MD, 82, Pompano Beach, Fla, died July 14, 1988, in Larsen. Born May 4, 1906, in the town of Winchester, Dr Anderson graduated from Northwestern University Medical School, Chicago, and served his internship at St Agnes Hospital in Fond du Lac. Dr Anderson practiced medicine in Neenah from 1938 to 1971. He served on the medical staff of Theda Clark Memorial Hospital and was a former staff president. He was a member of the Winnebago County Medical Society, the SMS, and the AMA. Surviving are his widow, Helen; one daughter, Annette Gleason, of St Louis; two sons, Dr Gay R., of Winneconne, and Larry J. of Elgin, Ill.

Stanley R. Miller, MD, 79, Stevens Point, died July 24, 1988, in Stevens Point. Born April 8, 1909, in Portage County, Dr Miller graduated from Marquette University School of Medicine and served his internship at St Mary's Hospital in Milwaukee. He had practiced in Stevens Point for 53 years. He was a member of the Portage County Medical Society, the SMS, and the AMA. Surviving are his son, Dr James D., of Stevens Point; three daughters, Madeline Davidson, of Tacoma, Wash; Kathleen Oertel, of Stillwater, Minn, and Janie of Stevens Point.■

A duty to report?

State legislation adopted in 1987—Stats 448.03(5)(b)—grants immunity to a physician who, in good faith, reports to the Wisconsin Department of Transportation a patient whose condition impairs his or her ability to drive. In its report to the House of Delegates at the annual meeting in April, the Committee on Safe Transportation noted that the law might also create an implied duty to report a person who, in the physician's judgment, is impaired. The committee urges physicians to report these patients and wishes to alert physicians to the potential interpretation creating liability for not doing so.■

Cecelia Geis

Maria Schmitt

Jim Esselman

New SMS staff

Three new staff members have joined SMS. Cecelia Geis has joined the Division of Medical Policy and Practice as a policy analyst. Her main areas of responsibility are medical liability, problems of the uninsured, and mental health issues. She will also help staff the Blue Ribbon Task Force on Alternatives to the Tort System. Cecelia was previously with the Office of the Commissioner of Insurance.

Maria Schmitt, who previously worked for the SMS from 1984 to 1986, has returned to the Society as an administrative assistant in the Division of Communications. She most recently worked at Marshall Erdman & Associates in Madison.

Jim Esselman is the new accounting manager for the SMS. A CPA, Esselman has more than 14 years experience in accounting and was most recently with Hill Christensen & Co in Eau Claire.■

Blue Book update

Please refer to page 114 of the July 1988 Blue Book edition of the *WMJ*. The new officers of the Wisconsin Dermatological Society, serving until October 1989, are:

Donald J. Miech, MD, president
1000 N Oak Ave
Marshfield, WI 54449

John S. Cantieri, MD, president-elect
17030 W North Ave
Brookfield, WI 53005

David K. Falk, MD,
secretary-treasurer
1313 Fish Hatchery Road
Madison, WI 53715

The new officers of the Wisconsin Society of Internal Medicine are:

Susan Turney, MD, president
1000 N Oak Ave
Marshfield, WI 54449

William J. Listwan, MD,
president-elect
279 S 17th Ave
West Bend, WI 53095

Robert E. Phillips, MD,
secretary-treasurer
1000 N Oak Ave
Marshfield, WI 54449

Please refer to page 112 of the July 1988 Blue Book edition of the *WMJ* for the following changes under the officers of specialty sections of the SMS:

Dermatology
(October 1989)

Donald J. Miech, MD, chairman
1000 N Oak Ave
Marshfield, WI 54449

John S. Cantieri, MD, chairman-elect
17030 W North Ave
Brookfield, WI 53005

David K. Falk, MD,
secretary-treasurer
345 W Washington Ave
Madison, WI 53703

Internal Medicine
(September 1989)

Susan Turney, MD, chairman
1000 N Oak Ave
Marshfield, WI 54449

William J. Listwan, MD,
secretary-treasurer
279 S 17th Ave
West Bend, WI 53095

Susan Turney, MD, delegate
William J. Listwan, MD,
alternate delegate■

CES Foundation
of the State Medical Society of Wisconsin

The persons and organizations named below made contributions to the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin during the month of August, 1988. The Foundation and the Society salute their generosity.

Voluntary contributions

Larkin N. Allen, MD
Raymond G. Bachhuber, MD
Durward A. Baker, MD
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Louis C. Bernhardt, MD
Lewis Chamoy, MD
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Daniel Danahy, MD
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Fema So Garay, MD
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Lerthai Pengtovong, MD
Evan F. Pizer, MD
Scott Springman, MD
K. Alan Stormo, MD
Roger H. Strube, MD
Joseph Trader, MD
Richard Ward, MD

Memorials

Fond du Lac County Medical Auxiliary
J.S. Huebner, MD
Kathy and Bob Mohelnitzky
Marie Shipley
State Medical Society of Wisconsin
Norma Swenson

Memorialized

Byron Bradley
Ignatious Cesnik
Thayer C. Davis, MD
Lawrence J. Keenen, MD

Beaumont 500

SMS Services, Inc

General Student Loan Fund

Kathy and Bob Mohelnitzky
Marie Shipley
Norma Swenson

Scholarships

Nelson Muffler Co

Fort Crawford Medical Museum

Crawford County■

Physician Needed
to Administer and Coordinate
SMS Statewide Impaired Physician Program
on an Independent Contractor Basis

The terms of the contract are negotiable. Certification eligibility by the American Medical Society of Alcoholism and Other Drug Dependencies, or five years experience in treatment of chemical dependency, is desirable. Special expertise in the treatment of doctors as patients is also a plus. Compensation will be commensurate with experience and the terms of the contract. Send inquiries and curriculum vitae to: Personnel Department, State Medical Society, PO Box 1109, Madison, WI 53701.

Substance abuse speakers available

The SMS Committee on Alcoholism and Other Drug Abuse has created a speaker's bureau of physicians and others knowledgeable about addiction. Speakers are available for a large number of topics, including cocaine abuse, chemical dependency and psychiatric disorders, and diagnosis and treatment of alcoholism.

Speakers are available to address medical, professional, business and civic groups. The list of speakers and topics is available from the SMS Communications Division (1-800-362-9080 or 608-257-6781) or Charles E. Goodell, MD (715-453-2181).■

Physicians Exchange

Internist with or without subspecialty interests. Board-certified or eligible to join a well-established nine man expanding multispecialty group. Location is in a southeastern Wisconsin city of 36,000 with access to a large inland lake, initial salary plus percentage as an associate. Full status in-service corporation with shared overhead and an incentive orientated formula after the first year. Please contact E.T. Ayala, MD, Department of Internal Medicine, Sharpe Clinic, SC, 92 East Division St, Fond du Lac, WI 54935; ph (414) 921-0560, collect. p6–11/88

West Bend, Wisconsin, General Clinic, a 20-physician multispecialty group is seeking additional B/C, B/E physicians in **Family Practice, Pediatrics, OB/GYN, Internal Medicine, Urology, Dermatology,** and **ENT.** First-year salary and benefits guaranteed. Corporate association after one year. Located in a family-oriented, economically strong small city surrounded by four-season recreational and scenic Kettle Moraine area 30 miles north of metropolitan Milwaukee. Contact Hans W. Schmelzling, Administrator, 279 S 17th Ave, West Bend, WI 53095; ph 414/338-1123. 7tfn/87

Family Practitioner to associate with a highly successful two physician (one physician near retirement) rural family health center with an excellent support staff and unlimited potential. Complete fee-for-service practice with excellent hospitals and specialty support only minutes away. Guaranteed salary, incentives and benefits tailored to fit your needs. Located 15 minutes from a major metropolitan area and 30 minutes from the joys of Door County. Interested physicians please contact: J. C. Majeski, Clinic Mgr, Luxemburg Medical Clinic, PO Box C, Luxemburg, WI 54217; ph 414-845-2351. p11–12/88;1/89

RATES: 50¢ per word, with a minimum charge of $20.00 per ad. BOXED AD RATES: $25.00 per column inch. *All ads must be prepaid.*

DEADLINE: Copy must be received by the 1st of the month preceding month of issue; *eg,* copy for the August issue is due July 1. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free in Wisconsin: 1-800-362-9080.

The Wausau Medical Center is seeking BC/BE individuals in the following specialties: Cardiology, Dermatology, Family Practice, Infectious Disease, Obstetrics/Gynecology, Pediatrics and Rheumatology. Modern clinic facility located across the street from modern 300-bed hospital. Full partnership in three years. Easy access to lakes, woods and mountains. Write including CV to D.K. Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, WI 54401. p4tfn/88

Family practice. Thirty-four physician multispecialty group conveniently located between Chicago and Milwaukee. Well-equipped clinic offering salary guarantee with incentive bonus; excellent fringe benefits and early ownership. Please send current curriculum vitae to Roger D. Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 4tfn/88

Physicians needed full- or part-time to perform light physicals. Milwaukee area. Professional liability provided. Phone 414/344-2100, Ms Jenkins. 10tfn/84

Independent practice opportunity, Eau Claire, Wis. Extremely busy Board-certified solo family practitioner seeks one to two FP associates. Practice located in newly 1987 constructed 11,000 square foot professional building which also houses a plastic surgeon, podiatrist, and pharmacy. Due to the size of the practice, an outstanding initial employment and compensation package is being offered as well as very attractive associate terms for full partnership after one year. Contact Donald Stewart at 414-731-3004 for additional information. 10–12/88

Eastern Iowa. Progressive young BC FP seeks residency trained BC FP for growing practice. Call every fourth night. Newly remodeled hospital. Active community 19 miles from Iowa's third largest city. Send CV to S. Hanas, MD, 1118 11th, DeWitt, IA 52742. 10–12/88

Wisconsin. OB/GYN (BC/BE) needed to join dynamic HMO-based multispecialty group practice. University town of 55,000 near Minneapolis. Community and recreation outstanding. Competitive salary and fringes. We take pride in our patient care. Contact Robert A. Braastad, MD, Group Health Cooperative, 1030 Regis Court, Eau Claire, WI 54701; ph 715-836-8552. p11–12/88;1–89

Orthopaedic Surgeon. Board-certified/eligible to join two well established orthopaedists in an actively expanding multispecialty southern Wisconsin clinic. New medical facility in a growing community of 50,000+. Modern "state of the art" hospital. Send CV to James Lube, Administrator, Janesville Medical Center, Ltd, 3524 East Milwaukee St, Janesville, WI 53546 or call 608-756-7122. 11–12/88;1/89

Psychiatrist/Chemical Dependency Psychiatrist interested in chemical dependency needed to join 220-physician multispecialty group with adjacent 447-bed hospital. Position includes inpatient services for Chemical Dependency Unit with full range of outpatient chemical dependency services available; Evaluation and Detoxification Unit; outpatient chemical dependency clientele and follow-up; general psychiatric practice also available. Behavioral Medical Department is presently staffed by seven psychiatrist, one child/adolescent psychiatrist and two psychologists. New clinic building recently completed. Gundersen Clinic, Ltd, is located in La Crosse, Wisconsin, a progressive community of 50,000 built along the shores of the Mississippi River amid scenic bluffs, the city offers excellent recreational facilities. Numerous educational and cultural opportunities are provided by an expanding university with undergraduate and graduate degree programs, and a private liberal arts college. Excellent pension program, no investment required. Service organization: Write Philip J. Dahlberg, MD, Chairman, Personnel Committee, Gundersen Clinic, Ltd, 1836 South Ave, La Crosse, WI 54601. An Equal Opportunity Employer. 11/88

Wisconsin—Emergency Medicine. Excellent clinical opportunities are currently available with Spectrum throughout Wisconsin. Low to moderate volume emergency departments. Varying schedules available. Guaranteed competitive rate of reimbursement, high-limit occurrence malpractice insurance coverage, Wisconsin Compensation Fund. For additional information, contact Ruth Sutterer, Spectrum Emergency Care, PO Box 27352, St. Louis, MO 63141; ph 1-800-325-3982, extension 3029. 11–12/88;1/89

Internist BE/BC. North Shore Internal Medicine, PC, is seeking an energetic general internist to enjoy the benefits of a rapidly expanding practice. New office close to hospital. Michigan State Medical School Campus. Send resume to 2420 First Ave, South, Escanaba, MI 49829; ph 906-786-1563. 10tfn/88

Physicians Exchange

continued

Staff Physician to join professional staff of accredited Student Health Center. Provide direct patient care, medical consultation, emergency treatment. Family practitioner, internist or pediatrician interested in adolescence and preventive medicine desired. Must have or be eligible for Wisconsin Medical license. Academic staff position is 39 weeks. Excellent fringes include professional liability. Begin Jan 17, 1989. Send application letter, vitae, names of three references, all postmarked by Nov 28, 1988, to Dr James Murphy, Director, Student Health Center, University of Wisconsin–La Crosse, La Crosse, WI 54601. Minority applicants encouraged. AA/EOE. 11/88

Immediate opening for family practitioner to join busy 13-physician multispecialty group in clean North Dakota lake country. Salary and fringe benefits very liberal. Send curriculum vitae or inquires to: Lake Regional Clinic, PC, PO Box 1100, Devils Lake, ND 58301, Attn: Joel Rotvold or call collect at 701-662-2157 for further information. 11–12/88;1/89

Come join me. Ambulatory care. Orange County, California. Good Hours. Great wages. Excellent amenities. Gerald J. Derus: 714-496-8641. 11tfn/88

RURAL WISCONSIN HOSPITAL COOPERATIVE

Emergency Room Physicians

The Rural Wisconsin Hospital Cooperative (RWHC) is a nationally recognized and award winning organization that provides advocacy and shared services for its 20 member hospitals. We are seeking ACLS certified physicians with Family Practice, Internal Medicine or ER backgrounds and strong communication skills to provide coverage for our participating hospitals. The hospitals served by RWHC are within a two-hour drive from Madison, Wisconsin. Many have ACLS trained nursing staffs and modern emergency room facilities. This network offers flexibility in scheduling, with needs ranging from part to full-time coverage. A competitive salary and access to a variety of benefit options is available.

Contact: Patricia Ruff, Associate Director, RWHC, 404 Phillips Blvd, Sauk City, WI 53583; 608-643-2343. 9/88

Seeking emergency department director and full-time physicians for 100-bed hospital 35 miles north of Milwaukee. Excellent compensation, malpractice insurance provided and benefit package provided. Contact: Emergency Consultants, Inc, 2240 S. Airport Road, Room 36, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496. p11/88

Partnership Opportunity, Wisconsin. Position available Jan 1, full-time and part-time, for ABEM Board-prepared/certified emergency physician to join young well established board-certified group. New facility, 25,000(+) visits, weekend double physician coverage, daily PA double coverage. Strong medical staff support. Easy access to Chicago, Madison, Milwaukee. Competitive reimbursement with full benefits package. Send CV to: Beloit Emergency Physicians, 1969 West Hart Road, Beloit, WI 53511. p11/88

Family Practitioner needed by progressive and stable HMO in west central Wisconsin city of 50,000. Highly competitive salary with excellent fringe. Practice high quality care in a good recreational area. Send CV to Robert Braastad, MD, 1030 Regis Court, Eau Claire, WI 54701; ph 715-836-8552. p10–12/88

Family Practice. Three-man group in Fort Atkinson, Wisconsin, seeking BC/BE family practitioner to fill position of retired partner, Full benefits, salary guarantee, opportunity to join SC after one year. 110-bed remodeled community hospital one block from office. All the benefits of rural living with access to urban areas in 30 minutes. Contact: Fort Atkinson Medical Center, 211 Memorial Drive, Fort Atkinson, WI 53538; ph 414-563-2404. p11–12/88

Twenty-nine physician multispecialty clinic located in desirable East Central Wisconsin location is seeking Board-certified or Board-qualified orthopedic surgeon to round out its services. Lab, x-ray, excellent hospital. Liberal guarantee and benefits. If interested contact D.F. Sweet, MD, Fond du Lac Clinic, SC, 80 Sheboygan St, Fond du Lac, WI 54935. 9tfn/87

NEW PHYSICIANS FOR WISCONSIN

is seeking

- Family Physicians
- Pediatricians
- Orthopedic Surgeons
- Internists

Contact: Fred Moskol
UW Office of Rural Health
810 University Bay Drive
Madison, WI 53705
608/263-7933
7–12/88;1–6/89

Family practice physician wanted to be associated with branch clinic of a large multispecialty group. Opportunity for family practice in Prairie du Chien, Whitehall, Viroqua or Tomah, Wisconsin; West Union, Iowa. Physician would be associated with a multispecialty group. Relief provided for vacations, meetings, etc. Educational opportunities through an excellent education program. Beautiful countryside, cultural and recreational facilities. Excellent fringe benefits. Salary commensurate with background and experience. Write or call: Tim Skinner, MSEd, Family Practice Representative, Gundersen Clinic, Ltd, 1836 South Ave, La Crosse, WI 54601. Equal Opportunity Employer. 11/88

Pediatrics. Marshfield Clinic, a 270-physician, multispecialty private group practice, is seeking a board-certified or eligible general pediatrician to join its expanding regional center in Chippewa Falls. Chippewa Falls is a community of 15,000 people located in beautiful west central Wisconsin with a wide range of recreational, educational, and cultural opportunities easily accessible. The clinic is adjacent to a 110-bed JCAH accredited hospital. Competitive salary and fringe benefit package. Send curriculum vitae and references to: Mr David Draves, Director, Regional Development, Marshfield Clinic, 1000 North Oak Ave, Marshfield, WI 54449, or you may call collect at 715-387-5376. 11/88

Michigan. Medical community seeking additional pediatricians. Call coverage available, several practice options. Hospital has well equipped nursery, 20-bed pediatric unit, and enthusiastic staff. Interest in neonatology a plus. Located near universities. Growing area has solid economic base and offers many cultural activities. Contact Rebecca Turley, 414-785-6500 (collect), or send CV to Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186.

Minnesota Internist seeks BE/BC internist to join his practice in Brainerd, a central Minnesota resort community. Beautiful lakes and expanding retirement area. New 162-bed hospital with all specialties. Offices in five year-old medical office building. Contact Michael O. Musty, MD, 1903 South Sixth St, Brainerd, MN 54601; ph 218-828-4082. 11tfn/88

Emergency Medicine, Otolaryngologist, Urologist, and Obstetrician/Gynecologist to join multispecialty group practice in Woodruff, WI. Guaranteed annual income and excellent fringe benefit program. Send CV to R.J. Sloan, MD, Lakeland Medical Associates, Ltd, PO Box 549, Woodruff, WI 54568. 4tfn/88

Physicians Exchange

continued

BC/BE General Internist to join 26-MD multispecialty group with four internists, one nephrologist and one gastroenterologist. Top salary first year, full incentive thereafter. Central Wisconsin university town with drawing area of 80,000. Send CV to Dr John Gauder, Rice Clinic, SC, 2501 Main St, Stevens Point, WI 54481, or call collect 715/344-4120. 12tfn/87

Family Practice (BC/BE) opportunity to join a five-physician family practice group in south central Wisconsin city of 15,000. Pleasant community atmosphere within 1–1½ hours of Madison and Milwaukee. Excellent recreational area. First year guaranteed salary. Contact: Chad Burchardt, Business Manager, Medical Associates of Beaver Dam, SC, 1200 N Center St, Beaver Dam, WI 53916; ph: (414) 887-7101. p9–11/88

Rheumatologist—the Racine Medical Clinic, a 34-physician multispecialty group conveniently located between Chicago and Milwaukee. Well equipped clinic offering salary guarantee with incentive bonus; excellent fringe benefits and early ownership. Please send curriculum vitae to: R.D. Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 11tfn/87

General and Vascular Surgeon, university trained, sought as ambitious associate for very busy surgeon. Rewarding, hard work in sophisticated medical community. Robert Mikkelsen, MD, FACS, 14 N Main St, Fond du Lac, WI 54935. p8;9–11tfn/88

Career opportunity for qualified Emergency Room physician. Our group covers two hospital emergency rooms and an active walk-in clinic in southeastern Wisconsin. Full fringe benefit package and flexible scheduling offered. Interested parties contact John W. Linstroth, MD, 1201 Sherwood Lane, Caledonia, WI 53108; ph 414-835-7761. 8tfn/88

Eagle River—Great opportunity for two BC/BE family practice physicians to join well-established practice. Guaranteed annual income and future partnership available. For more information, send resume to Judy Harris, Recruiter, UW Office of Rural Health, 810 University Bay Dr, Madison, WI 53705 or call collect 608/263-7933. 1tfn/88

Beloit Clinic, SC, an expanding multispecialty group in southern Wisconsin college town is seeking a pulmonologist, radiologist, allergist, ophthalmologist, and orthopaedic surgeon for its main facility, as well as a second family practitioner for a satellite location. Guaranteed salary with incentive plus excellent fringe benefits. Send CV to J. F. Ruethling, Administrator, 1905 Huebbe Parkway, Beloit, WI 53511; ph 608-364-2200. 10–12/88;1–3/89

Miscellaneous

For lease. West Allis, Milwaukee. Medical office is newly remodeled waiting for lessee's finishing choices. Prime intersection location, parking. Five exam rooms, reception and waiting rooms, office, lab. Available now. Equipment leasing also available. Call Glenda Holm at 414-765-0558 for details. p11/88

Medical Facility for rent/downtown Wautoma, Wisconsin. Three examining rooms, waiting room, receptionist area, record room, preparation room, x-ray room, dark room, full bathroom with shower. Available Oct 1. Call 414-787-2562 for more information. 11/88

Real Estate

For Rent. Doctor's Office, Hales Corners, Wisconsin, area 1050 sq ft. New building, first floor, ample parking. Reception, business office, three plumbed examining rooms, laboratory, private office and bath. For information call 414-764-6692 or 414-744-8007. 8tfn/88

Wisconsin Specialty Society Meetings: 1989

Wisconsin Orthopaedic Society, May 5, 1989, American Club, Kohler.

Wisconsin Chapter: American Academy of Pediatrics, May 22, 1989, Milwaukee.

Wisconsin Academy of Family Physicians, June 21–24, 1989, Radisson Hotel, La Crosse.

Wisconsin Society of Obstetrics & Gynecology, July 20–22, 1989, Radisson Hotel, La Crosse.

Wisconsin Society of Internal Medicine, Sept 14–16, 1989, Embassy Suites, Green Bay

Medical Meetings—Continuing Medical Education

February 5–8, 1989: American Society for Parenteral and Enteral Nutrition's 13th Clinical Congress at the Fontainebleau Hilton, Miami Beach, Florida. Info: A.S.P.E.N., 8605 Cameron St, #500, Silver Spring, MD 20910; ph 301-587-6315. p11/89

MARCH 5–10, 1989: Cardiology for the Clinician: Practical Guidelines for Merging Advances in Cardiology with Bedside Medicine at Snowmass, Colorado. (Further details elsewhere in this section.) g11–12/88

JUNE 21–24, 1989: Wisconsin Academy of Family Physicians, Radisson Hotel, La Crosse g11tfn/88

SEPTEMBER 14–16, 1989: Wisconsin Society of Internal Medicine, Embassy Suites, Green Bay, Wisconsin. g11tfn/88

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, clinics, specialty societies, and medical schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 50¢ per word, with a minimum charge of $20.00 per listing. *All listings must be prepaid.*

BOXED LISTINGS: $25.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 1st of the month preceding the month of publication; *eg*, copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free in Wisconsin: 1-800-362-9080.

FOR LISTING of other meetings see the July 1, 1988 issue of the *Journal of the American Medical Association:* Continuing Education Opportunities for Physicians for period August 1988 through December 1988.

Medical Meetings—Continuing Medical Education

continued

AMA

DECEMBER 4–7, 1988: Interim House of Delegates, Dallas, TX.

JUNE 18–22, 1989: Annual AMA House of Delegates, Chicago, IL.

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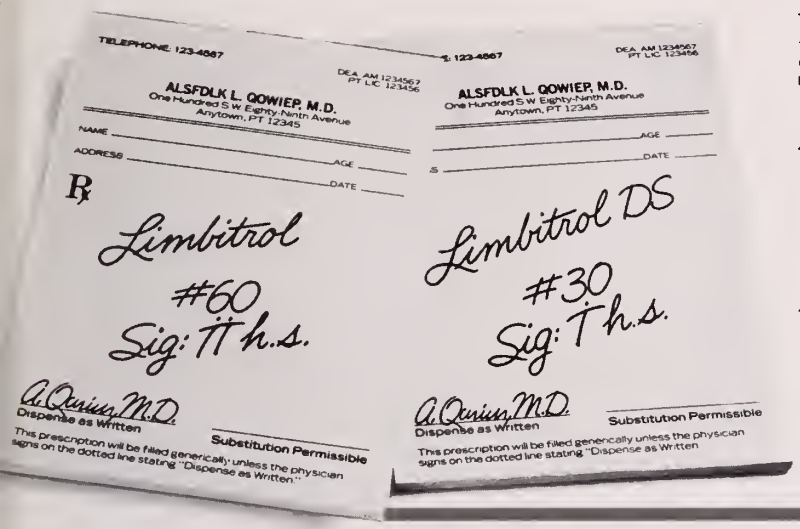

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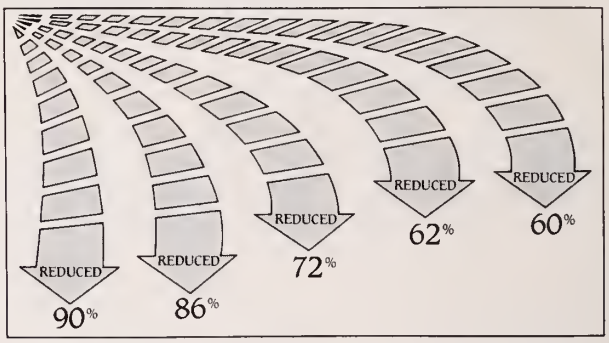

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Wisconsin Medical Journal

Official Publication of the State Medical Society of Wisconsin

Aging

December 1988

V. 87, NO. 12

Wisconsin Medical Journal

The *Wisconsin Medical Journal* (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor and editor are responsible for overseeing the production, business operation and contents of the journal. The editorial board, chaired by the medical editor, solicits and screens all scientific, special and soundings articles. The editorial director provides leadership for the editorial associates and comments on both editorials and letters to the editor. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *WMJ* nor the SMS take responsibility. The *WMJ* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

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Our cover: "Human Comedy" an oil painting by Aaron Bohrod. Presented to the SMS Charitable, Educational, and Scientific Foundation, the painting is on display at SMS headquarters in Madison.

Season's Greetings from SMS Services

We wish to thank you
for your valued support
throughout the past year
and
extend our very best wishes to you
for a Prosperous and
Happy New Year.

President's page

Can we control health care costs?

THE QUESTION that is the title of this opinion column (or opinionated column, if you prefer) comes from a front page headline of a prominent Wisconsin newspaper two months ago. This headline introduced an installment in a series on health care which described and deplored the inexorable growth of illness costs in the past two decades. The same question is also much in the minds of the public (patients, physicians, legislators, regulators, insurers, governors, economists, advocates and business executives).

All right, we know the question, but what is the answer? The blunt answer is that we have not and probably cannot control health care costs. The blunt reason is that the public won't permit it. How so and why not?

Health care is so highly valued in our contemporary culture that the desire for anything identified as health care is insatiable when the costs are borne by someone else. Efforts by government to saturate this demand for ("improve access to") health care have resulted in more (too many?) doctors, Medicare, Medicaid, comprehensive health planning, regional medical programs, Hill-Burton hospitals and ever broader insurance mandates.

Health care has evolved into a sociopolitical right and a societal entitlement. In the view of the public, any effort to limit access (meet need rather than demand) to health care is a violation of the public's rights and a denial of that to which the public is entitled. The public, when it is ill or injured, wants more, not less, care. The public knows that more (CAT scans, dialysis, transplant surgery, coronary by-pass grafts, angioplasty, mammograms, infertility evaluations, newer medicines) can be had than ever before. Accordingly, expectations expand and expenditures soar.

As a prominent Wisconsin official once said, "when costs become visible, purposes are questioned." The public has questioned the rising costs of illness care, assigned the blame to hospitals and physicians and demanded cost control by regulation. Certificate of need, a moratorium on nursing home construction, utilization review, DRG prospective pricing and resource-based relative value scales are products of the regulation theory of cost control. Because public expectations (and demands for more for more care) grew as fast as the regulations, the volume of services rose and costs escaped containment.

The next phase (chaotically overlapping with previous phases) of cost containment has grown out of the classical competition theory of supply and demand. If we can't drive down costs by increasing the supply and if it is politically impossible to limit demand, then let competition reduce costs, said the public. Thus, we have HMOs, hospitals, clinics and physicians competitively (and expensively) advertising (the older term is soliciting, the newer term is outreach) services to the public and thereby stimulating more demand. Meanwhile, back in the legislature, special interest groups petition to have more spent on their health concerns, limited-license (so-called) health providers lobby to enlarge their permitted scope of practice and additional health-related occupations organize to attain recognition and licensure so they too can collect from the government and insurers, avoid

JD Kabler, MD

the need for referral (go around the gate of the keeper) and promote their services directly to the public (the ultimate payor).

As each subset of the public has sought to maximize its own advantage and shift costs to others, the always finite health care resources are consumed and prices rise relentlessly. Some groups—the uninsured, for example—have been priced out of participation. Unmet needs of these groups together with the growing needs of the ailing elderly and those with HIV infections will force higher, not lower, expenditures. These social, political, demographic and biological forces have been and probably will remain irresistible. There is no publicly (politically) acceptable method of health care cost reduction: Supply expansion, regulation, competition and gate-keeping have failed.

Who is really to blame? The public (all of us) may come to acknowledge that the late Walt Kelly was right when he said through the mouth of his cartoon character, Pogo, "we have met the enemy and they are us." Politics is the ultimate reality.■

Editorials

United we stand

LAST SPRING, at the SMS annual meeting, the past presidents had their dinner. For those of us who had the honor, it was a very enjoyable evening.

This year, each member was asked to speak briefly as to what he felt was the major problem facing the medical profession today. Almost unanimously, it was felt to be the high cost of medical care, and at least the perceived failure to control or contain the rapid rise. Obviously, this is not just a problem for the medical profession and—with or without our leadership and influence—a solution or perceived solution will be forthcoming, whether we like it or not.

My remarks went beyond the cost issue by saying that we cannot solve or affect the solution unless we physicians can act as a united group. I believe the biggest problem facing the medical profession is that we are being divided primarily on economic issues, and if we cannot stand together as a profession, we are lost. My concern is that more and more we are putting our own individual specialties with their interests and practice first. If the surgeons cannot accept relative value scales they don't like, or pathologists or radiologists want to make separate deals with the government on payment, we are divided—and divided we shall see the profession lose the battle. Jack Mullooly, MD, addressed this issue very well in his editorial in the August issue of the *Wisconsin Medical Journal*, which was the impetus for me to write this letter.

Earl Thayer's remarks concerning this issue were to the effect that the new relative value scale might well be the force that really splits the profession.

It's time to let specialty societies concentrate on quality of care in their particular fields, and we as physicians all get together behind the AMA and SMS to act for the profession as a whole. If you don't like what they are doing, get involved and speak up within the societies, but keep the profession as a profession. Let us not become a group of employed workers concerned about forming a union.

—Russell Lewis, MD
Madison■

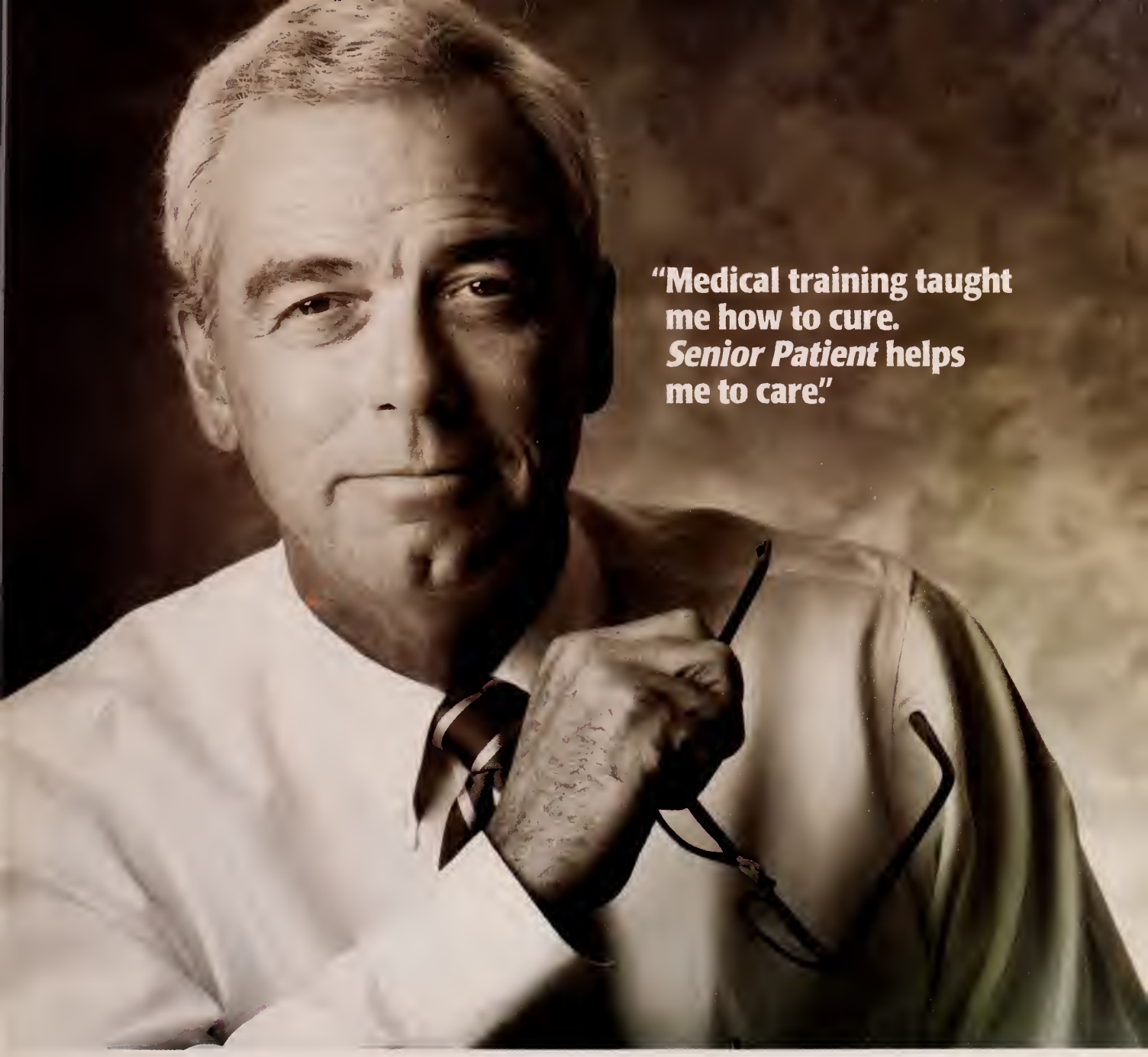
Respecting the human being

IN 1954, WHILE I WAS PREPARING for medical school, the movie "Not as a Stranger" was being seen across America. To me, the most moving scene was in the beginning when Brodrick Crawford, the crusty pathologist, entered an amphitheater occupied by young, joking medical students, and silenced them with a short statement as he was about to commence an autopsy—"Gentlemen, this is the body of a man who recently lived, laughed, had sorrows just as you and I. He was a human being and deserves our respect and should be treated with dignity. Never forget that and treat him accordingly"—or words to that effect.

The impact of this statement on the students was palpable as they absorbed its meaning. Their expressions changed from nervous jocularity to deep and solemn concern. The message they heard—treat the dead with a reverence befitting the dignity of a once living person—had an impact on them.

Have we, as a medical profession, the same attitude of reverence for the

Continued on page 6.



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human person as we once had? Or is this reverence for the human being slowly eroding under the force of the prevailing value system of the technological, scientific and medical communities which are increasingly allowing their ends to justify all means? Are we slowly losing, by way of our scientific and medical successes, the basic values which we have so deeply cherished for so long? These are the questions we must ask ourselves in these days of what some call runaway technology.

When we consider the vast changes that have occurred in the past 30 years, in both society and medicine, we can see less and less value being placed on the individual's innate dignity and autonomy. Many patients complain of the increasingly impersonal character of our health care facilities and their personnel. There seems to be a growing distrust of the medical profession, and patients are trying to gain control of their own lives and destinies. We see a growing demand for patients to take charge of their own treatments, to the extent that active voluntary euthanasia is openly advocated. And at the other end of the spectrum, we see the sickeningly mounting statistics of abortions performed every year, throughout the world. But perhaps the most disturbing manifestation of our recent insensitivity is the increased agitation for permission to use aborted fetuses for scientific experimentation—all under the rubric of the tremendous medical benefits to be derived from such experiments.

Such agitation gives in vitro fertilization research new implications. While lauded in many circles for its success in bringing babies to the new world, its deeper implications are not much talked about (eg, the experimentation that goes on with discarded embryos). If a person is shown no respect as a zygote, there is little hope for respect during the rest of life—and even less in the final years.

The preciousness of human life, with all of its implications, is certainly being eroded in our time. The future does not bode well for us as human beings with respect to being treated with the dignity our human nature demands. With the increasing demands for cutting health care costs, we can see that less value will be placed on the old, the chronically ill, the mentally ill, and the defective newborn.

If this scenario sounds familiar, it is not surprising. We need look only as far as Germany of the 1920s, '30s and '40s, where lives deemed unworthy to be saved were snuffed out by physicians who forgot their underlying commitment to "do no harm." They forgot about the dignity of human personhood and their central ethic to be healers.

The disturbing news from the Netherlands in regard to involuntary euthanasia being practiced along with voluntary euthanasia, the battles in Australia and Great Britain in regard to non-therapeutic fetal experimentation, and the recent decision by a US government committee to permit fetal experimentation, all demonstrate how far we have strayed from respect we should have for the innate dignity of the individual.

The underlying philosophies that have permeated and desensitized us all are utilitarianism and subjectivism. As human beings, we are living out the consequences of this philosophy. The human race and all of its individual members will be the poorer for it. As a medical profession, it is incumbent upon us to reflect upon these issues and to recommit ourselves to the values handed down to us by our forbearers in medicine. Perhaps, as we do this bit of reflection on the implications of modern biotechnology, we shall be able to recapture the spirit of reverence for the human being so dramatically portrayed so long ago by Brodrick Crawford in "Not as a Stranger," and so well exemplified by the physicians who guided us in our formation as practitioners in the science and art of medicine.

—John P. Mullooly, MD
Milwaukee■

Soundings
Progress

Richard P. Barthel, MD, Milwaukee

FAMILY LEGEND TELLS
My gramma was
1½ pounds in 1907,
kept in a cigar box
wrapped in cotton and nurtured,
she lived.
It's hard to believe, now.

Fact is
when I was an intern,
in 1970–'71,
a paper bag was in the neonatal kit,
for babies "too small to live."
We put them on a shelf
for a few hours and ignored them.
Now, it's hard to believe.

Everybody knows
in our ICU last year
an "800 gramer" stayed for two
months.
She had surgery twice,
the bill was over $250,000.
Mom didn't see her for
five weeks.
She died, nobody cried.
It's true, nowadays.■

Dr Barthel is with the department of psychiatry and mental health sciences at the Medical College of Wisconsin. Reprint requests to: Richard P. Barthel, MD, Children's Hospital of Wisconsin, PO Box 1997 MS #744, Milwaukee, WI 53201.
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BE AS LOFTY AS LAËNNEC WITHOUT LETTING YOUR BUSINESS SUFFER.

René Théophile Laënnec, (1781-1826) the French physician who developed the stethoscope.

Laënnec was a genius in diagnosis, but his practice fell flat. *StrategiCare* could have helped him be a genius in both.

In his time it was said that while Laënnec was "without rival in diagnosis, he was not a good practitioner," according to historians. The famous man who authored "De l'Auscultation Médiate" and developed the stethoscope had no business and marketing strategy to give his diagnostic methods credibility or build a sound practice. His findings helped to isolate the symptoms of tuberculosis, yet he was considered misguided in treatment.

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Secretary's report

Farewell to a friend

DECEMBER 31 WILL MARK the end of an era at SMS. H.B. "Bernie" Maroney informed me in September that he would leave the Society at year end. There comes a time in all our lives when we are compelled to answer the call of new endeavors and new adventures, and Bernie is answering his by hanging out his shingle in the private practice of law.

Bernie first joined the SMS in 1962 as a legislative clerk. Fortunately for both Bernie and the Society, that title did not last long. As his career with the Society progressed, he eventually served as counsel and assistant secretary to three secretaries of the Society: Charles Crownhart, Earl Thayer and me. During that 26 years, Bernie had many responsibilities. At various times he was responsible for governmental affairs, the CES Foundation and safe transportation issues, to name but a few.

While looking after all of the above interests, however, Bernie has probably been best known for the sound and sage advice he has given many of you on legal matters. Whether the questions related to contracts, peer review, malpractice, or personal problems, Bernie has been there when you needed him.

Since 1976, Bernie has served two masters, working half of his day for SMS and devoting his other working hours to serving as executive director of the Interstate Postgraduate Medical Association (IPMA). He will continue in that capacity after leaving SMS.

During the past two and a half years, I have developed a sincere appreciation of Bernie's insight, understanding of SMS, and love for the medical profession. In looking back through his personnel file, I ran across his first performance review, conducted by Earl Thayer on Feb 6, 1963, after just four months on the job. In that memo Earl states in part: "He (Bernie) is a dogged worker in running down the answers to specific problems. He is not afraid to express an opinion on the way some things are done or might be done."

Thomas L. Adams

Earl's remarks more than 25 years ago are, to me, the hallmark of Bernie's tenure with SMS. I will miss him, but I wish him well in his continuing involvement with IPMA and the private practice of law.

While good people come and go, the hallmark of this Society staff has been its consistent high quality. New staff members bring new ideas and enthusiasm. The same degree of dedication exhibited by Bernie is shared by all the members of your staff. Between the leadership exhibited by you and the hard work of the staff, I am confident that the Society will continue to meet the challenges of providing quality health care to our fellow citizens in the years ahead.

The staff and I wish for each of you a joyous holiday season.■

What 26 years at the SMS can do: H.B. "Bernie" Maroney before (left) and after (right).

(ciprofloxacin HCl/Miles)

A REVOLUTIONARY ORAL ANTIMICROBIAL WITH THE POWER OF PARENTERALS

- **Highly active *in vitro* against a broad range of gram-positive and gram-negative pathogens, including methicillin-resistant *Staphylococcus aureus* and *Pseudomonas aeruginosa****
- **For treatment of infections in the:**
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  - **–urinary tract†**
  - **–skin/skin structure†**
  - **–bones and joints†**
- **Convenient *B.I.D.* dosage – 250 mg, 500 mg and 750 mg tablets**

**In vitro* activity does not necessarily imply a correlation with *in vivo* results.

†**Due to susceptible strains of indicated pathogens. See indicated organisms in Brief Summary.**

CIPRO* SHOULD NOT BE USED IN CHILDREN, ADOLESCENTS, OR PREGNANT WOMEN.

A history of hypersensitivity to ciprofloxacin is a contraindication to its use. A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin.

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Please see adjacent page of this advertisement for Brief Summary of Prescribing Information.

Cipro® TABLETS
(ciprofloxacin HCl/Miles)

■ 500 mg q12h for most infections;
750 mg q12h for severe or complicated infections.

CIPRO®
(ciprofloxacin hydrochloride/Miles)
TABLETS

BRIEF SUMMARY
CONSULT PACKAGE INSERT FOR FULL PRESCRIBING INFORMATION

INDICATIONS AND USAGE

Cipro® is indicated for the treatment of infections caused by susceptible strains of the designated microorganisms in the conditions listed below

Lower Respiratory Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Proteus mirabilis, Pseudomonas aeruginosa, Haemophilus influenzae, Haemophilus parainfluenzae,* and *Streptococcus pneumoniae*

Skin and Skin Structure Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Proteus mirabilis, Proteus vulgaris, Providencia stuartii, Morganella morganii, Citrobacter freundii, Pseudomonas aeruginosa, Staphylococcus aureus* (penicillinase and nonpenicillinase-producing strains), *Staphylococcus epidermidis,* and *Streptococcus pyogenes*

Bone and Joint Infections caused by *Enterobacter cloacae, Serratia marcescens,* and *Pseudomonas aeruginosa*

Urinary Tract Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Serratia marcescens, Proteus mirabilis, Providencia rettgeri, Morganella morganii, Citrobacter diversus, Citrobacter freundii, Pseudomonas aeruginosa, Staphylococcus epidermidis,* and *Streptococcus faecalis*

Infectious Diarrhea caused by *Escherichia coli* (enterotoxigenic strains), *Campylobacter jejuni, Shigella flexneri,** and *Shigella sonnei** when antibacterial therapy is indicated

*Efficacy for this organism in this organ system was studied in fewer than 10 infections

Appropriate culture and susceptibility tests should be performed before treatment in order to isolate and identify organisms causing infection and to determine their susceptibility to ciprofloxacin. Therapy with Cipro® may be initiated before results of these tests are known; once results become available appropriate therapy should be continued. As with other drugs, some strains of *Pseudomonas aeruginosa* may develop resistance fairly rapidly during treatment with ciprofloxacin. Culture and susceptibility testing performed periodically during therapy will provide information not only on the therapeutic effect of the antimicrobial agent but also on the possible emergence of bacterial resistance.

CONTRAINDICATIONS

A history of hypersensitivity to ciprofloxacin is a contraindication to its use. A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin.

WARNINGS

CIPROFLOXACIN SHOULD NOT BE USED IN CHILDREN, ADOLESCENTS, OR PREGNANT WOMEN. The oral administration of ciprofloxacin caused lameness in immature dogs. Histopathological examination of the weight-bearing joints of these dogs revealed permanent lesions of the cartilage. Related drugs such as nalidixic acid, cinoxacin, and norfloxacin also produced erosions of cartilage of weight-bearing joints and other signs of arthropathy in immature animals of various species (SEE ANIMAL PHARMACOLOGY SECTION IN FULL PRESCRIBING INFORMATION).

PRECAUTIONS

General: As with other quinolones, ciprofloxacin may cause central nervous system (CNS) stimulation, which may lead to tremor, restlessness, lightheadedness, confusion, and very rarely to hallucinations or convulsive seizures. Therefore, ciprofloxacin should be used with caution in patients with known or suspected CNS disorders, such as severe cerebral arteriosclerosis or epilepsy, or other factors which predispose to seizures (SEE ADVERSE REACTIONS).

Quinolones may also cause anaphylactic reactions and cardiovascular collapse. Anaphylactic reactions may require epinephrine and other emergency measures.

Crystals of ciprofloxacin have been observed rarely in the urine of human subjects but more frequently in the urine of laboratory animals. Crystalluria related to ciprofloxacin has been reported only rarely in man, because human urine is usually acidic. Patients receiving ciprofloxacin should be well hydrated, and alkalinity of the urine should be avoided. The recommended daily dose should not be exceeded. Alteration of the dosage regimen is necessary for patients with impairment of renal function (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

Drug Interactions: Concurrent administration of ciprofloxacin with theophylline may lead to elevated plasma concentrations of theophylline and prolongation of its elimination half-life. This may result in increased risk of theophylline-related adverse reactions. If concomitant use cannot be avoided, plasma levels of theophylline should be monitored and dosage adjustments made as appropriate.

Antacids containing magnesium hydroxide or aluminum hydroxide may interfere with the absorption of ciprofloxacin, resulting in serum and urine levels lower than desired; concurrent administration of these agents with ciprofloxacin should be avoided.

Probenecid interferes with the renal tubular secretion of ciprofloxacin and produces an increase in the level of ciprofloxacin in the serum. This should be considered if patients are receiving both drugs concomitantly.

As with other broad-spectrum antibiotics, prolonged use of ciprofloxacin may result in overgrowth of nonsusceptible organisms. Repeated evaluation of the patient's condition and microbial susceptibility testing is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Information for Patients: Patients should be advised that ciprofloxacin may be taken with or without meals. The preferred time of dosing is two hours after a meal. Patients should also be advised to drink fluids liberally and not take antacids containing magnesium or aluminum concomitantly or within two hours after dosing. Ciprofloxacin may cause dizziness or lightheadedness; therefore patients should know how they react to this drug before they operate an automobile or machinery or engage in activities requiring mental alertness or coordination.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Eight *in vitro* mutagenicity tests have been conducted with ciprofloxacin and the test results are listed below:

- Salmonella/Microsome Test (Negative)
- *E. coli* DNA Repair Assay (Negative)
- Mouse Lymphoma Cell Forward Mutation Assay (Positive)
- Chinese Hamster V_{79} Cell HGPRT Test (Negative)
- Syrian Hamster Embryo Cell Transformation Assay (Negative)
- *Saccharomyces cerevisiae* Point Mutation Assay (Negative)
- *Saccharomyces cerevisiae* Mitotic Crossover and Gene Conversion Assay (Negative)
- Rat Hepatocyte DNA Repair Assay (Positive)

Thus, two of the eight tests were positive, but the following three *in vivo* test systems gave negative results:

- Rat Hepatocyte DNA Repair Assay
- Micronucleus Test (Mice)
- Dominant Lethal Test (Mice)

Long-term carcinogenicity studies in animals have not yet been completed.

Pregnancy – Pregnancy Category C: Reproduction studies have been performed in rats and mice at doses up to six times the usual daily human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ciprofloxacin. In rabbits, as with most antimicrobial agents, ciprofloxacin (30 and 100 mg/kg orally) produced gastrointestinal disturbances resulting in maternal weight loss and an increased incidence of abortion. No teratogenicity was observed at either dose. After intravenous administration, at doses up to 20 mg/kg, no maternal toxicity was produced, and no embryotoxicity or teratogenicity was observed. There are, however, no adequate and well-controlled studies in pregnant women. SINCE CIPROFLOXACIN, LIKE OTHER DRUGS IN ITS CLASS, CAUSES ARTHROPATHY IN IMMATURE ANIMALS, IT SHOULD NOT BE USED IN PREGNANT WOMEN (SEE WARNINGS).

Nursing Mothers: It is not known whether ciprofloxacin is excreted in human milk, however, it is known that ciprofloxacin is excreted in the milk of lactating rats and that other drugs of this class are excreted in human milk. Because of this, and because of the potential for serious adverse reactions from ciprofloxacin in nursing infants, a decision should be made to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Ciprofloxacin should not be used in children because it causes arthropathy in immature animals (SEE WARNINGS).

ADVERSE REACTIONS

Ciprofloxacin is generally well tolerated. During clinical investigation, 2,799 patients received 2,868 courses of the drug. Adverse events that were considered likely to be drug related occurred in 7.3% of courses, possibly related in 9.2%, and remotely related in 3.0%. Ciprofloxacin was discontinued because of an adverse event in 3.5% of courses, primarily involving the gastrointestinal system (1.5%), skin (0.6%), and central nervous system (0.4%).

The most frequently reported events, drug related or not, were nausea (5.2%), diarrhea (2.3%), vomiting (2.0%), abdominal pain/discomfort (1.7%), headache (1.2%), restlessness (1.1%), and rash (1.1%).

Additional events that occurred in less than 1% of ciprofloxacin courses are listed below. Those typical of quinolones are italicized.

GASTROINTESTINAL *(See above),* painful oral mucosa, oral candidiasis, dysphagia, intestinal perforation, gastrointestinal bleeding

CENTRAL NERVOUS SYSTEM *(See above), dizziness, lightheadedness, insomnia, nightmares, hallucinations, manic reaction, irritability,* tremor, *ataxia, convulsive seizures, lethargy, drowsiness, weakness, malaise, anorexia, phobia, depersonalization, depression,* paresthesia

SKIN/HYPERSENSITIVITY *(See above), pruritus, urticaria, photosensitivity, flushing, fever, chills,* angioedema, *edema of the face, neck, lips,* conjunctivae *or hands,* cutaneous candidiasis, hyperpigmentation, erythema nodosum

Allergic reactions ranging from urticaria to anaphylactic reactions have been reported

SPECIAL SENSES *blurred vision, disturbed vision, (change in color perception, overbrightness of lights), decreased visual acuity, diplopia, eye pain, tinnitus, bad taste*

MUSCULOSKELETAL *joint or back pain, joint stiffness,* achiness, neck or chest pain, flare-up of gout.

RENAL/UROGENITAL *interstitial nephritis, renal failure,* polyuria, urinary retention, urethral bleeding, vaginitis, acidosis

CARDIOVASCULAR palpitations, atrial flutter, ventricular ectopy, syncope, hypertension, angina pectoris, myocardial infarction, cardiopulmonary arrest, cerebral thrombosis

RESPIRATORY epistaxis, laryngeal or pulmonary edema, hiccough, hemoptysis, dyspnea, bronchospasm, pulmonary embolism

Most of these events were described as only mild or moderate in severity, abated soon after the drug was discontinued, and required no treatment.

In several instances, nausea, vomiting, tremor, restlessness, agitation, or palpitations were judged by investigators to be related to elevated plasma levels of theophylline possibly as a result of a drug interaction with ciprofloxacin.

Adverse Laboratory Changes: Changes in laboratory parameters listed as adverse events without regard to drug relationship:

Hepatic – Elevations of ALT (SGPT) (1.9%), AST (SGOT) (1.7%), alkaline phosphatase (0.8%), LDH (0.4%), serum bilirubin (0.3%)

Hematologic – eosinophilia (0.6%), leukopenia (0.4%), decreased blood platelets (0.1%), elevated blood platelets (0.1%), pancytopenia (0.1%).

Renal – Elevations of Serum creatinine (1.1%), BUN (0.9%).

CRYSTALLURIA, CYLINDRURIA, AND HEMATURIA HAVE BEEN REPORTED.

Other changes occurring in less than 0.1% of courses were: Elevation of serum gammaglutamyl transferase, elevation of serum amylase, reduction in blood glucose, elevated uric acid, decrease in hemoglobin, anemia, bleeding diathesis, increase in blood monocytes, and leukocytosis.

OVERDOSAGE

Information on overdosage in humans is not available. In the event of acute overdosage, the stomach should be emptied by inducing vomiting or by gastric lavage. The patient should be carefully observed and given supportive treatment. Adequate hydration must be maintained. In the event of serious toxic reactions from overdosage, hemodialysis or peritoneal dialysis may aid in the removal of ciprofloxacin from the body, particularly if renal function is compromised.

DOSAGE AND ADMINISTRATION

The usual adult dosage for patients with urinary tract infections is 250 mg every 12 hours. For patients with complicated infections caused by organisms not highly susceptible, 500 mg may be administered every 12 hours.

Respiratory tract infections, skin and skin structure infections, and bone and joint infections may be treated with 500 mg every 12 hours. For more severe or complicated infections, a dosage of 750 mg may be given every 12 hours.

The recommended dosage for infectious diarrhea is 500 mg every 12 hours.

In patients with renal impairment, some modification of dosage is recommended (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

HOW SUPPLIED

Cipro® (ciprofloxacin HCl/Miles) is available as tablets of 250 mg, 500 mg, and 750 mg in bottles of 50, and in Unit-Dose packages of 100 (SEE FULL PRESCRIBING INFORMATION FOR COMPLETE INFORMATION).

CONVENIENT *B.I.D.* DOSAGE

Recommended dosage schedule

Infection Site*	Severity of Infection	Dosage
Respiratory Tract*	Mild/Moderate	500 mg q12h
Bone and Joint*		
Skin/Skin Structure*	Severe/Complicated	750 mg q12h
Urinary Tract*	Mild/Moderate	250 mg q12h
	Severe/Complicated	500 mg q12h
Infectious Diarrhea*	Mild/Moderate/Severe	500 mg q12h

***Due to susceptible strains of indicated pathogens.**
See indicated organisms in Prescribing Information.

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C09858A MLR-558

Theories of aging

Ronald I. Shorr, MD, and Molly Carnes, MD, Madison

AGING DESCRIBES the irreversible time-dependent changes that occur in biological systems once peak vitality has been reached. These changes usually are associated with functional impairment and jeopardize survival. In humans, age beyond the third decade is associated with greater mortality and, therefore, represents an intrinsic risk factor for dying. The relationship between age and mortality was first described more than 150 years ago by an insurance actuary, Samuel Gompertz. Gompertz recognized that human mortality doubles every seven years; a 70-year-old man has twice the risk of dying as a 63-year old, four times the risk of dying as 56-year old and so on. Similar mathematical models have been constructed to predict mortality in other animal species.

When this article was prepared, Dr Shorr was with the Geriatrics Section of the William S. Middleton Memorial Veterans Hospital in Madison. He has since joined the Department of Medicine of Case Western University and University Hospitals of Cleveland. Dr Carnes is with the Department of Medicine and Psychiatry at the University of Wisconsin–Madison. Reprint requests to: Ronald Shorr, MD, Geriatric CARE Center, University Hospitals of Cleveland, 2074 Abington Road, Cleveland, OH 44106 (telephone: 216-844-7246). Copyright 1988 by the State Medical Society of Wisconsin.

In most unprotected animal species, as in ancient man, the impact of aging on mortality is never realized because factors extrinsic to the organism, such as predators and environmental hardship, play a much larger role in the determination of survival. Industrialized man, protected from many extrinsic causes of mortality, lives to experience physical deterioration associated with aging, also referred to as senescence. Survival is threatened by disease processes related to biological decay such as atherosclerosis and malignancy. Whether aging actually causes these lethal syndromes or whether aging predisposes the host to their onset remains a topic of intense investigation.

Two additional terms germane to this discussion require definition. *Life span* refers to the maximum survival potential of a species under ideal conditions in the absence of trauma or disease. This is a species-specific, and, therefore, genetically determined, trait. The longest documented human survival was 115 years. Homo sapiens comprise the longest lived mammalian species. Most estimates suggest that the average maximum life span for humans is approximately 100 years. Other species with relatively long life span potentials include the Indian elephant (77 years), the hippopotamus (50 years) and the chimpanzee (50 years), genetically our closest cousin. The life expectancy of the mouse, a species in which much aging research has been performed, is approximately two years.

Despite vast differences in life spans among species, similar age-related events are observed in all mammalian species. It is the *rate of aging*, therefore, that is different among the species. Results from studies in comparative evolution suggest that the species-specific rate of aging appears to be controlled by only a few genes; however, the existence of aging genes has yet to be documented.

In contrast to life span, *life expectancy* is derived from actuarial tables and represents the average duration of life for any given population. Average life expectancy is usually measured from birth; it reflects a measure of survival specific to a

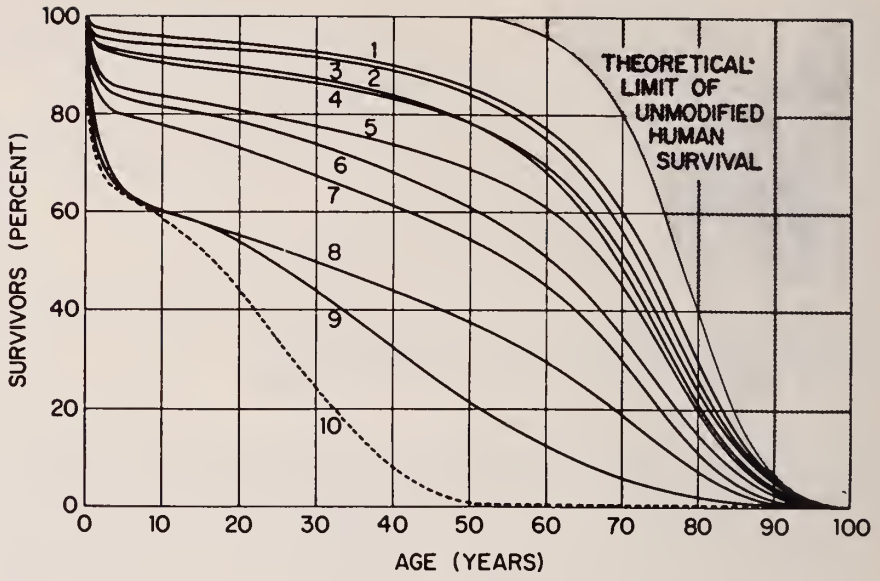
Life span *v* life expectancy

Population	Life expectancy (years)	Maximum life span (years)
Rome (50 AD)	32	85–100
US (1900)	47	85–100
US (1980)	75	85–100
Ethiopia (1980)	42	85–100

demographically defined group at a specific place or time (see the Table). The average life expectancy of a child born in the United States in 1900 was 47 years; today it is nearly 75 years. The increase of approximately 30 years in life expectancy in the 20th century has been ascribed largely to improved public health measures and primary prevention of many childhood infectious diseases. Life expectancy can be measured from any point in life. For example, the average life expectancy of an 85 year old is approximately five years. This means an individual who survives to 85 years can expect, on average, to live an additional five years. Recent analysis of the survival curve for this country has shown some of the largest gains in life expectancy for those over 85, often referred to as the "old old."

Survival can be plotted on a curve with age on the X axis and percent surviving on the Y axis. Graphs may be superimposed to compare survival in different populations. At the turn of the century, the leading causes of death in this country were influenza, pneumonia, tuberculosis, and infectious diarrheal illness. These illnesses affected infants and middle-aged adults causing premature mortality. The survival curve of the US population in 1900 was nearly linear, reflecting a population in which extrinsic causes played a larger role in mortality than intrinsic causes, such as aging. In industrialized cultures today, many of these causes of death have been eradicated, can be prevented, or are curable, and as a result, a greater proportion of our population is surviving into old age. The present survival curve for the United States, reflecting this greying of America, appears more rectangular (Fig 1).

It should be kept in mind that in developing nations, the pattern of mortality, and the survival curve, appears today quite similar to that of the United States before the impact of public health and medical advances. In the United States and



1 New Zealand, 1934–1938
2 U.S. (Whites) 1939–1941
3 U.S. (Whites) 1929–1931
4 England and Wales, 1930–1932
5 Italy, 1930–1932
6 U.S. (Whites), 1900–1902
7 Japan, 1926–1930
8 Mexico, 1930
9 British India, 1921–1930
10 Stone Age man

Fig 1.—Human survival curves under varying circumstances of socieconomic development, such development being accompanied by decreasing pediatric mortality (From Comfort A: The Biology of Senescence. *New York, Rinehart & Winston, Inc, 1956, 1964 and 1979; with permission).*

other modernized nations, chronic illnesses have replaced acute illness as the major causes of death. In one study, no cause of death could be ascertained in 30% of elderly individuals, with the authors suggesting "old age" as the ultimate cause of these deaths.

As improvements in diagnosis and treatment bring under control the chronic illnesses that currently cause death in modernized nations, what will the future hold as more individuals die a "natural death" (ie, of old age)?

It has been estimated that if the three major causes of death (cardiovascular disease, cancer and stroke) were eliminated, an increase in life expectancy of only 13 years would be realized because of the biologically determined maximum life span. Will chronic care consume a larger proportion of health care expenditures, or will the suppression of chronic disease allow for greater vigor and less dependency in our increasingly large population of older adults? Two opposing views will be highlighted in the following section.

Some gerontologists, such as James Fries, believe that while personal choices can delay the onset of morbidity from chronic diseases, humans, like all higher organisms, obey species-specific limitations of survival, and even extraordinary manipulations will have little impact in delaying mortality. Using trends in life expectancy over the last 50 years, Fries has calculated the ideal human life span at approximately 85 years (Fig 2).

Fries defines life as "internal homeostasis." As normal aging ensues, an organism loses "organ reserve," rendering it less able to maintain homeostasis when confronted with even small perturbations. Chronic medical conditions such as coronary artery disease, arthritis and cancer represent syndromes of accelerated loss of organ

reserve. The rate at which aging, or loss of organ reserve, occurs varies tremendously between individuals. This plasticity of aging can be taken advantage of, within broad limits, by individuals' choosing to maintain cardiac, respiratory and musculoskeletal reserve through regular exercise and proper diet. Fries espouses the view that the onset of chronic illness may be "postponed" through adherence to healthful lifestyles. For example, the loss of pulmonary organ reserve, which occurs normally in aging, will be accelerated by smoking. Premature loss of organ reserve stems from disuse and misuse. "Use it or lose it" has become the axiom of geriatric practitioners; maintenance of regular physical and mental activity is recommended as one of the personal choices one can make to delay the onset of chronic illness and disability.

If life span is fixed and the onset of chronic diseases can be delayed, then theoretically, morbidity may be compressed into a short period near the end of the natural life span. On a societal level, Fries envisions a future where adults will live independently until near the end of a fixed, 85-year life span when, like Oliver Wendell Holmes's "one-hoss shay," everything comes apart, and repair is impossible. In this scenario, chronic care burdens would be minimal and little effort spent on senselessly prolonging life at the end of the life span. Hospices would replace hospitals in the care of aged adults as they approach their terminal drop.

Edward Schneider and Jacob Brody are among the gerontologists who disagree with this point of view. They suggest that while, in general, the survival curve has moved toward a rectangular configuration, more recent life table analysis shows a "derectangularization" of this survival curve for the old old. These authors reason that if the survival curve were to continue becoming more rectangular, stable high mortality rates for those near 85, producing the sharp drop at the end of the survival curve, would be expected. Furthermore, to produce this steep side of the rectangle, decreasing variance of mortality around the point of a maximum of life expectancy would also be expected. Census bureau data reveal that neither of these changes in mortality is occurring. Instead, the mortality rates for those 85 and older are falling at a greater rate than for those aged 75 to 84, and variance of age at death appears to be increasing.

Schneider and Brody envision a world filled with increasing numbers of persons aged 90 and over who, in all likelihood, will be suffering from the same chronic diseases that afflict today's elderly.

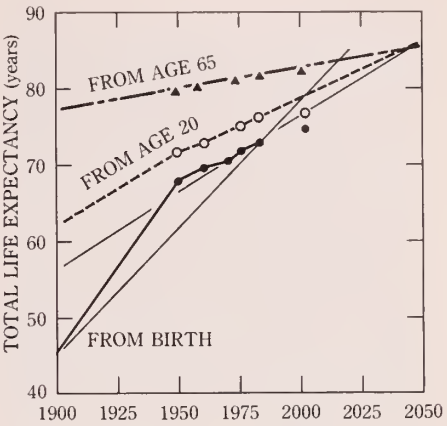


Fig 2—Trends, limits, and convergences in life expectancy (From Fries J; Aging, natural death, and the compression of morbidity. N Engl J Med *1980;303:130–5; with permission).*

Selected models of aging

The senescence of cells and organisms can be compared to the time-dependent changes that occur in other complex systems, such as the brand new, finely tuned automobile. Like the automobile, which relies on effective electrical, mechanical, and combustive activity for operation, vitality of the cell or organism relies on the competent and coordinated function of multiple component systems. Over the life span of the automobile, several years of problem-free performance can be expected, unless premature mortality from trauma (ie, a major accident) occurs. Inevitably, automobiles show signs of aging. Despite normal maintenance, parts begin to wear out. Rust corrodes the body and chassis. The car may accumulate small damages, which ultimately rob it of its youthful vigor, and it may be more susceptible to accidents because safety features fail. Unless unusual measures are taken to preserve the vehicle, the automobile becomes too expensive to maintain and too unreliable to drive. Eventually, the car is retired to the scrap yard, where its component parts may be transplanted into other vehicles.

Two distinct mechanisms may be responsible for automobile aging as described above. Perhaps timed self-destruction is built into each new vehicle at birth on the assembly line. The owner of such a product would be disappointed to find the automobile, even if never driven, in total disrepair after a certain number of years. Such planned obsolescence might result from the programmed failure of one critical part, such as the engine, with the subsequent catastrophic demise of all dependent systems or programs. Alternatively, automobile aging may result from the accumulation of small insults, incurred during vehicular use, to a wide range of parts. Automobile manufacturers and mechanics are quite aware of this wear-and-tear phenomenon, which may explain why warranties are limited by mileage, as well as by time.

Theories of programmed senescence and wear and tear have also been applied to the aging of cells and organisms, and the next section will review evidence favoring the occurrence of both in biological systems. Theories of programmed senescence are based on experimental evidence demonstrating scheduled decay in critical physiologic functions occurring in both in vitro and in vivo systems. These changes may ultimately result in the loss of vitality of the cell or organism. Wear-and-tear theories are based on evidence that cytotoxic

by-products of metabolism or structural defects caused by external sources accumulate with the passage of time and cause cell dysfunction and death. Errors in replication, transcription and translation of genetic material may result in changes in somatic expression at the cellular level. It is possible that the accumulation of such errors, or just one critical error, may cause cell death and lead to changes associated with aging at the level of the organism.

Programmed senescence. Central to the aging organism are the changes that occur in its component cells with senescence. Early in this century, the question of somatic cell immortality was addressed by Alexis Carrel, who claimed that he was able to keep fibroblasts from a chick heart multiplying indefinitely. The culture was terminated after 34 years with a number of other laboratories confirming the maintenance of so-called immortal cell lines from human and animal tissues. The concept of somatic cell immortality changed dramatically when Hayflick proved that these immortal cell lines had undergone transformation by either irradiation or chemical carcinogens—and no longer consisted of normal somatic cells. Working with fibroblasts from human fetal lung tissue, Hayflick demonstrated that normal somatic tissues are capable of only a finite number of population doublings, and cessation of population doubling is one of many time-dependent deteriorations of cellular function that can be described as senescence at the cellular level.

Fibroblasts maintained in cell culture under normal conditions were shown to be capable of undergoing approximately 50 population doublings. Experimentation by Hayflick's group has shown that for normal cultured human cells, the number of divisions remains constant despite being frozen at -20 °C for prolonged periods. For example, cells capable of 50 doublings will complete an additional 20 divisions if frozen after completing 30 population doublings. Further studies, using enucleation and cell fusion techniques, have demonstrated that when nuclei from young cells, (those having undergone ten population doublings) are transplanted into cytoplasm from older cells (those having undergone, for example, 35 population doublings), these hybrid cells can be made to undergo 40 subsequent population doublings as determined by the age of the nucleus. An old nucleus, on the other hand, will limit the number of population doublings when transplanted into a young cell. These studies imply that a cellular chronometer exists in the nucleus rather than cytoplasm and provides evidence that the number of potential population doublings is under genetic control. Experimental work of this nature favors the idea that aging, at the level of the cell, may occur as part of a genetic plan. Much is being done to elucidate the molecular mechanisms of this aging program.

Studies performed by several investigators have demonstrated that normal somatic cells have a finite life span when maintained in vivo as well as in vitro. Unlike cancer cells, which divide continuously when sequentially transplanted, grafts of rodent mammary tissue, skin and hematopoietic tissue do not survive indefinitely when transplanted between animals over several life spans.

The research produced by Hayflick and colleagues has generated a great deal of interest in the mechanisms that control aging at the cellular level. Whether programmed senescence of cells in tissue culture can be extrapolated to the complex events that occur during aging at the level of the organism, however, is unknown.

Like the automobile, which requires adequate functioning of many separate, but interrelated, components, the living organism demands competent and coordinated functioning of many diverse organ systems for survival. Each organ system declines physiologically with age, but rates of deterioration vary significantly. Certain organ systems are critical to survival. These include the immune, central nervous, and cardiovascular systems. These systems have attracted a good deal of interest in the study of aging. This section will discuss some of the deteriorations that occur in these systems with the passage of time—age-related erosion that is associated with illness and mortality.

Infections and malignancy contribute greatly to mortality in the elderly. The immune system is intimately involved in protecting the organism from these conditions. The thymus gland, an organ that promotes the maturation of T-lymphocytes, undergoes progressive involution with aging beyond adolescence. Perhaps consequently, T-lymphocyte function, assessed using skin test reactivity, declines with age. Anergy, defined as the complete inability to mount a skin test reaction to common antigens, usually represents severe T-lymphocyte impairment and is associated with elevated mortality in older adults.

B-lymphocytes, cells that produce antibodies, also exhibit declining function with age. The incidence of abnormal antibody-producing states, such as multiple myeloma and Waldenstroms macroglobulinemia, increases with age and may represent extreme examples of such age-related B-lymphocyte dysfunction.

Thymic hormone, a substance found in decreasing amounts with age has been shown to augment immune responsiveness in elderly patients. Reconstitution of the immune system, through the use of thymic hormone and other interventions, may prove to be clinically beneficial in turning back this proposed timekeeper of senescence, but much work remains to be done in this area.

Nearly a century ago, the French physiologist, Brown-Sequard, injected testicular extracts into old men (including himself) and reported increased strength and mental func-

tion. Since that time, the relationship between the endocrine system and aging has been explored. Recent advances have shifted the direction of aging research from glandular hormone secretion to areas of the brain, such as the hypothalamus, that regulate endocrine function through direct (neurotransmitters) and indirect (hormonal) means. For example, one of the best studied models of programmed senescence is the aging of the hypothalamic-pituitary-gonadal axis in females. Although the precise mechanism of the menopause remains controversial, the neuroendocrine system orchestrates the loss of reproductive ability. Further support for the existence of a neuroendocrine pacemaker of aging includes the following: the removal of the pituitary has been shown to delay signs of aging in experimental animals; and L-DOPA, a drug that undergoes metabolism to the neurotransmitter dopamine, has shown life-extending properties in animals.

Wear and tear. Free radicals exist in nature as an atom or groups of atoms that carry an unpaired electron. Examples of oxygen containing free radicals include the superoxide ($0_2 \cdot^-$) and the hydroxyl radical (OH·). These products are short lived, but they alter and ultimately damage cell membranes, DNA, and proteins. Endogenous sources of free radical production include oxidant enzymes, such as xanthine oxidase, cyclooxygenase, and lipoxygenase. Oxygen radicals also arise as by-products of cells involved in the immune response, including neutrophils, macrophages, and eosinophils. These compounds may be formed from mitochondrial and microsomal electron transport chains as well. Exogenous sources of free radicals include drugs, such as acetaminophen, and toxic substances, such as carbon tetrachloride and paraquat. Cigarette smoke has been noted to contain high concentrations of free radicals, and free radical damage to lung and oral mucosa has been proposed as one mechanism involved in the high incidence of cancers of these tissues seen in smokers. Free radicals are also thought to be involved in a number of other clinical conditions, ranging from autoimmune conditions to cataract formation.

There are several mechanisms, enzymatic and non-enzymatic, that protect the cell from free radical damage. Superoxide dismutase enzymatically converts superoxide radicals to hydrogen peroxide and oxygen. Other proteins that scavenge free radicals include albumin and ceruloplasmin. Vitamin E and glucose have also shown activity in quenching free radicals.

Free radical damage may be implicated in several conditions seen in aging, including atherosclerosis, Alzheimer's disease, and immune deficiency of aging. Research in this area has been forwarded greatly by Denham Harman. Harman has been able to prolong the average life span of laboratory mice by 10% to 30% using diets high in free radical scavengers. Mice fed these diets accumulated amyloid (protein by-products which have been associated with cellular damage) much less frequently than mice fed diets without free-radical inhibitors.

Lipofuscin, discussed below, is believed to arise from free radical reactions. Although no single cause will satisfactorily explain the myriad changes that occur in aging, free radical damage stands as an attractive hypothesis for some of the wear and tear seen in susceptible tissues. Further studies are needed to clarify the relationship between free radicals and senescence.

Lipofuscin, the aging pigment, is thought to consist of the oxidative breakdown products of organelles. Lipofuscin accumulates in cells with the passage of time, and is found in highest concentrations in senescent cells. Increased amounts of lipofuscin have been found in the brain tissue of patients suffering from Alzheimer's disease. Some investigators have suggested that lipofuscin accumulation interferes with the metabolic activity of neurons, while other authors, using different models, are unable to find impairments in neurologic function attributable to lipofuscin. Meclofenoxate, a lipofuscin-removing agent, has been proposed by some for use as life prolonging intervention.

Collagen from infants will readily dissolve when treated with the protease pepsin, whereas collagen from elderly donors resists pepsin digestion. Biochemical studies have ascribed this lack of solubility to the formation of covalent cross-links. Some researchers have proposed that accumulations of cross-linked collagen and elastin may be the underlying cause of age related stiffening of connective tissue and skin and may account for altered membrane permeability in senescent cells. Although changes at the molecular level may contribute to certain anatomic and physiologic changes in aging, little evidence supports the process of collagen cross-linking as the primary event in senescence.

Work by Cerami and coworkers has shown that nonenzymatic glycosylation initiates a series of chemical reactions that result in the accumulation of irreversible cross-links in a variety of proteins. Nonenzymatic glycosylation may serve as a mechanism underlying the formation of collagen cross-linkages described above. If a protein persists in the body for a prolonged period, the molecule slowly dehydrates and rearranges itself into a structure that can combine nonenzymatically with glucose to form an Amadori product. Amadori products continue to dehydrate and combine irreversibly with other molecules to form advanced glycosylated end products, which may bridge with other end products to form permanent covalent cross-links.

Experimental evidence linking these reactions to crystalline formation on ocular lens proteins suggests that accumulation of these end products may be responsible for at least

one common change in aging: cataract formation. Advanced glycosylated end products have also been proposed as etiologic agents in other age-related phenomena, such as the formation of atherosclerosis and capillary basement membrane thickening.

Glucose appears to react with cell constituents other than proteins. Experiments incubating DNA with glucose show nonenzymatic binding to occur, perhaps altering the structure of this genetic material. Studies of bacteria suggest that nucleic acids altered in this manner may interfere with genetic functioning, and the effects of advanced glycosylated end product on human DNA is currently undergoing investigation. Diabetics appear to develop many age-related diseases prematurely. An excess of glucose may cause accelerated formation of advanced glycosylated end products, resulting in cataracts, atherogenesis, renal dysfunction, and premature death. Diabetes may represent a syndrome of accelerated aging, which will be elaborated upon in the next section.

Bernard Strehler has proposed that the primary aging event at the cellular level involves the loss of genetic material with the passage of time. Strehler studied units of genetic material, called codons, that serve as templates in the synthesis of ribosomal DNA. He found that dogs lose this genetic material at a rate seven times faster than humans, a rate which, interestingly, corresponds to the ratio of maximum longevity of these species. Successive loss of genetic material, or codon restriction, results in the deletion of messages that direct the cell to produce products necessary for cell replication and other important functions. Ultimately, the progressive loss of genetic messages required to produce vital proteins results in cell senescence and death.

The human genome has been estimated to contain nearly 10^{10} DNA base pairs. Although much of this chromatin remains inert, precise transcription and translation of a large amount of detailed genetic information is required for survival. Damage to DNA can occur following exposure to irradiation, free radicals, or through formation of covalent cross-links. Estimates have shown that damage to DNA occurs at a tremendous rate in mammalian cells. One group, for example, described 2,300 single stranded DNA breaks in one hour. Given the vast amount of copying and coding that occurs during the maintenance of even non-dividing cells, the likelihood that errors will occur at some point in protein synthesis is quite high. Somatic cell mutations, resulting from damaged DNA, have been proposed by Szilard to be a primary event in aging.

In support of this theory, some researchers have noted that species with longer life expectancy exhibit better ability to repair DNA than short-lived species. Opponents of this school of thought point to studies demonstrating that chromatin damage induced by irradiation causes shortened life span, but no other signs of accelerated aging in animal models. Others point out that while the somatic mutation theory would predict the presence of extra genetic material, allowing the organism to tolerate a greater number of mutations before reaching a critical threshold, life expectancy is often decreased in clinical syndromes of excess chromatin, such as Down's syndrome. On theoretical grounds, it is argued that random mutations of DNA could not result in the remarkably non-random process of senescence.

Orgel has hypothesized that an inexact transcription of the proteins that process genetic information is responsible for aging at the cellular level. This proposal, labeled the error-catastrophe theory, suggests that the cell is susceptible to errors in the production of proteins of two classes. Faulty proteins involved in structural or metabolic processes may produce transient impairments of certain cell maintenance functions, but cellular performance normalizes once these imperfect peptides are degraded or replaced. On the other hand, the imprecise production of peptides that orchestrate information transfer for further protein production may create a negative feed-back loop (eg, faulty RNA polymerase may initiate the production of further copies of faulty RNA polymerase, which may result in the production of a multitude of other faulty peptides and so on). Eventually, errors accumulate such that the cell can no longer survive.

Manipulations that induce production of abnormal proteins, such as the dietary substitution of amino-acid analogues, have been used in animal and insect models by some investigators to test the error-catastrophe theory. If the error catastrophe theory holds, such interventions would be expected to bring about changes that shorten life span and accelerate aging. Such experiments, however, have yielded conflicting results. In addition, various techniques probing for production of anomalous proteins have not found consistently higher concentrations of defective peptides in senescent in vivo and in vitro systems.

Clinical syndromes of accelerated aging

Werner's syndrome. First described early in this century, Werner's syndrome is an extremely rare disease; it is an autosomally recessive inherited disorder. These patients, characterized by their shortened stature, develop premature cataracts, skin wrinkling, glucose intolerance, changes in voice, menopause, and atherosclerosis by the third decade.

While these patients appear to be physically aged, some of the features present in this disease are not common in normal aging. For example, in normal aging there is a predisposition to a variety of carcinomas, but in Werner's syndrome there is a predisposition to rare sarcomatous tumors. The ocular changes seen in aging include cataract formation in

the nucleus of the lens; the cataracts of Werner's syndrome, also called juvenile or endocrine cataracts, involve opacification of the posterior surface of the lens.

Other characteristics unique to Werner's syndrome include laryngeal atrophy and ulcerations of the extremities. In vitro studies of cultured skin fibroblasts from patients with Werner's syndrome exhibit decreased population doubling potentials, and have retarded DNA replication, but possess normal levels of DNA repair capability.

Progeria. Also called the Hutchinson-Gilford syndrome, progeria was first described late in the 19th century. Like Werner's syndrome, it is an extremely rare disease transmitted in an autosomal recessive manner. Patients with this syndrome develop many physical characteristics of aging at an earlier age than patients with Werner's syndrome. Wrinkled skin, stooped posture, and growth retardation are apparent by age 2. Cataracts, skin ulcers, and glucose intolerance—common in Werner's syndrome—are not characteristic of progeria. Patients with progeria display striking degrees of atherosclerosis involving nearly all the major vessels, and myocardial infarction is the most common cause of death, usually by age 30. Lipofuscin, has been found in unusually high concentration within the cells of many tissues. One group has observed increased enzyme alterations in progeric fibroblasts, above levels seen in senescent normal fibroblasts. Studies involving alterations in DNA repair mechanisms have not revealed consistent decreases in such processes.

From these preliminary studies, it appears that genetically directed production senescent enzymes might play a role in pathogenesis of this fascinating disorder.

Down's syndrome. Sometimes known as mongolism, Down's syndrome is a well-described congenital abnormality. Children born with Down's syndrome have characteristic facies and rarely exceed the stature of a normal 10-year-old child. Down's syndrome children exhibit varying degrees of mental retardation, often have heart defects, and show an increased incidence of leukemia. Trisomy of chromosome 21, or translocation of its parts, is thought to be the underlying genetic defect. In his review of syndromes thought to represent accelerated aging, Martin felt Down's syndrome most typified the phenomenon.

Persons with Down's syndrome display premature development of vascular disease, glucose intolerance, predisposition to malignancy, degenerative bone and joint disease, hair loss and lipofuscin and amyloid deposition. The life span is markedly reduced in Down's syndrome, with only 20% of these patients surviving past age 30.

Patients with Down's syndrome may also develop early dementia. At autopsy, brains from Down's syndrome patients reveal amyloid deposition neuritic plaques and neurofibrillary tangles, bearing striking resemblance to the postmortem findings of Alzheimer's disease. This observation has prompted some investigators to examine chromosome 21 for clues to the etiology of Alzheimer's disease.

Diabetes mellitus. Diabetes produces many sequelae that might be interpreted as accelerated aging. Diabetics develop premature cataracts, immune dysfunction, and renal insufficiency. Accelerated atherosclerosis, a common finding in these patients, leads to premature cardiac and vascular disease. Diabetes carries an increased risk of mortality and decreased life span, unless it develops at age 75 or beyond, when no statistically significant changes in mortality are noted.

The incidence of diabetes increases with age and approaches 800 in 100,000 in octogenarians. While fasting blood glucose remains unchanged with normal aging, the ability to maintain euglycemia when challenged with an oral glucose load deteriorates with the passage of time. In one study, nearly half of subjects over age 75 exhibited abnormally high plasma glucose levels one hour following an oral glucose load. Older subjects generally display a normal or increased insulin response to glucose challenge, but some have ascribed this finding to decreased insulin breakdown and suggest that a mild pancreatic insufficiency may explain in part the high frequency of glucose intolerance in older age groups. Animal studies have shown that age produces a number of insulin receptor and post-receptor defects; this observation suggests that insulin resistance may also play a role in the postprandial hyperglycemia seen in the elderly.

Hyperglycemia produces higher tissue concentrations of advanced glycosylated end products. Glycosylated hemoglobin (Hemoglobin A1c) is used as a method to assess long term glucose control. As described above, advanced glycosylated end products are associated with tissue alterations in vitro that mimic the changes of aging. Cellular and subcellular correlations between aging and diabetes remain a topic of intense interest.

Life prolongation

A number of dietary, lifestyle, pharmacologic, and surgical interventions appear to prolong life span and life expectancy in selected animal models. This section will summarize current prospects for such a fountain of youth in humans.

Numerous studies with rodents have demonstrated that severe caloric restriction will prolong life. The degree of caloric restriction imposed on these laboratory animals would be impractical to attempt in human studies. Milder degrees of caloric restriction, however, when applied at critical points in development (eg, in early life) result in a moderate life extension in rodents. Caloric restriction has been shown to retard the development of signs of aging at the

cellular level as well. Before studies of caloric restriction are tried on humans, however, more information regarding the relationship between caloric intake, adiposity, obesity, and longevity must be elucidated.

Retrospective studies examining the longevity of athletes have shown no relationship between a history of vigorous exercise early in life and prolonged life span. Increases in life expectancy and life span have, however, been seen in animals subjected to exercise early in life. Although these animals lost weight as a part of their exercise program, it appears that exercise contributes independently to the longer life of these animals. In humans, exercise programs started even late in life result in improved glucose tolerance, lipid profiles, and cardiovascular performance, but longitudinal studies are needed to discern whether prolongation of life can result from lifelong exercise regimes.

As discussed above, the free radical theories of aging have stimulated the investigation of dietary antioxidants to retard the development of senescence. A number of dietary antioxidants, such as Vitamin C, Vitamin E, and selenium, have been shown to prolong life span in experimental animals, but it is unclear if these agents delay other signs of aging. In some of these studies, animals fed antioxidant diets lost more weight than control animals, making it difficult to ascribe prolongation of life span solely to the intervention. Further studies are needed before ingestion of dietary antioxidants can be widely recommended. While tissue levels of the enzyme superoxide dismutase correlate well with species life span, there is no evidence that dietary supplementation of this enzyme prolongs life in humans or animals. Ingestion of superoxide dismutase, which is widely available at health food stores, does not raise levels of this enzyme in blood or tissue. Like all dietary proteins, this large molecule is degraded by proteases in the gut and absorbed in the small bowel as single amino acids and small peptides.

Centrophenoxine decreases tissue levels of lipofuscin in a variety of laboratory animals, and long-term administration of this drug has been shown to extend both life expectancy and life span in some animal models. In human trials, this agent has caused a dramatic weight loss and reduced fasting glucose levels. Little is known about the pharmacologic effects of centrophenoxine, however, and whether its use will improve human life span or expectancy remains to be seen.

The neurotransmitter dopamine is found in decreasing concentrations in the nigrostriatal areas of the brain with aging. This loss is hypothesized to be causally related to some of the clinically observed changes in motor tone, coordination, and gait with aging, and may be related to the high incidence of Parkinson's disease in the aging population. Long-term administration of high dose levodopa, a dopamine precursor, in mice has been reported to increase survival significantly. Animals ingesting this drug, however, also lost a significant amount of weight, making it difficult to discern whether the drug or weight loss alone delayed mortality in these studies. Although levodopa is used successfully in the treatment of Parkinson's disease, high doses of this drug have been associated with significant toxicity in humans, and it remains an unlikely candidate for life prolongation.

Donner Denkla popularized a theory that the pituitary secretes a hormone, yet to be characterized, which causes the aging of tissues and death by blocking the action of other anterior pituitary hormones on their target tissues. In support of this theory, removing the pituitary (hypophysectomy) with replacement of specific hormones such as thyroid and cortisol has been shown to prolong life in laboratory animals. This procedure has been shown to retard the development of age-related biochemical (ie, collagen cross linkages) and physiological deterioration. Again, the problem of weight comes into consideration—the hypophysectomized animals weighed less than the control animals.

As discussed above, immune competence clearly declines with age, and this decline may leave the organism susceptible to a variety of infectious insults and, ultimately, death. Attempts to rejuvenate the immune system through transplantation of tissues including thymus, bone marrow, and lymphocytes have increased survival in laboratory animals that are congenitally immune deficient, but has not lead to prolonged life in mice with normal immune system function. Pharmacologic interventions, including such immune stimulating agents as coenzyme Q, thymic hormone, and interlukin-2 are in the preliminary stages of investigation.

Dehydroepiandrostosterone (DHEA) is a mild androgenic steroid that exists in human blood primarily in sulfated form. Although significant concentrations of this hormone exist in newborns, blood levels fall throughout life. Administration of this agent to mice susceptible to tumors decreases the development of breast cancer. When DHEA is fed to mice susceptible to immune system failure, the characteristic development of autoimmune phenomenon and death are delayed. Additional studies, using more appropriate animal models, need to be completed before the initiation of human trials.

Although any pharmacologic intervention proposed for use in humans must be tested in animal models, the relevance of animal life span to humans remains in question. Caloric restriction and weight loss appear to be the only true model of life prolongation. Many of the interventions described above resulted in weight loss as a side effect, so it is difficult in many cases to attribute prolongation of life to the specific intervention.

If an effective means of life extension is discovered for humans, con-

siderations beyond mere biological effectiveness surface. Of paramount concern would be the ethical considerations of prolonged human life span. Who, for example, would be chosen for life extension? Perhaps each of us would like to live an additional youthful 150 years, but could society change in ways that would humanely accommodate increasing numbers of bicentenarians? Further investigations into the basic mechanisms of the aging process may ultimately yield methods to prolong human life, but until we solve the physical, emotional, and financial dilemmas that plague today's aging population, simply adding years to the maximum life span appears to be a misdirected endeavor.

Acknowledgment
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Salmonella and nursing home residents

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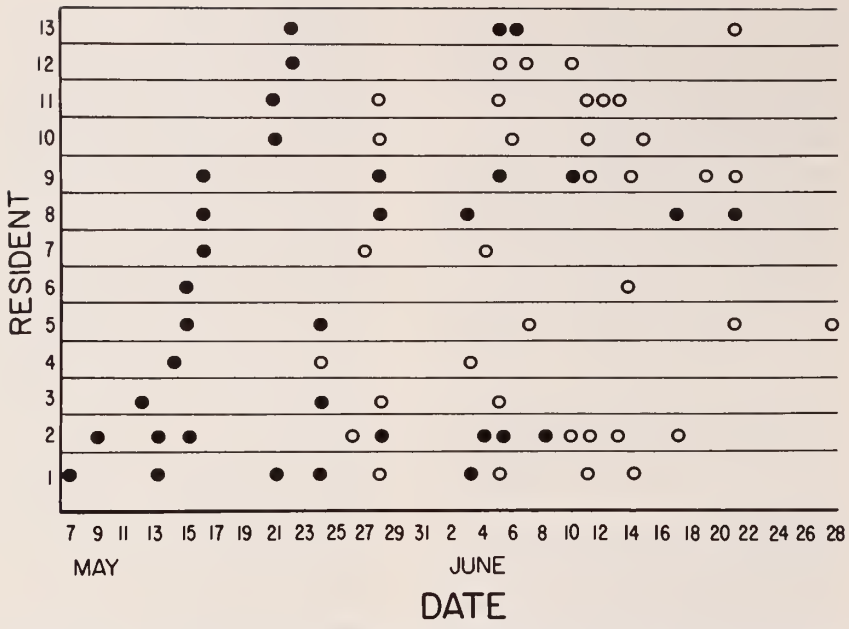
As a result of the hospitalization of two nursing home residents with salmonellosis, a stool culture survey of residents and staff of the nursing home was undertaken to determine the number of persons carrying *Salmonella*. One hundred forty-three residents and 63 staff members were cultured for *Salmonella*, and cultures were positive in 12 residents and one staff member. One resident carried *Salmonella* over a 37-day screening period. Three serotypes—*S heidelberg* (9), *S senftenberg* (2), and *S reading* (2)—were detected, with none of the stools examined containing mixed *Salmonella* serotypes. Only four culture-positive patients—three residents and the one staff member—were considered symptomatic, ie, having fever or diarrhea.

Asymptomatic carriers may serve as a source for nosocomial infection in the growing population of nursing home residents, who may serve as a reservoir of multiple and otherwise infrequently isolated serotypes.

THERE ARE CURRENTLY between 1 and 2 million residents in the 23,065 nursing homes in the United States, more than the number of patients in acute care hospitals.[1] The number of persons over age 65, currently about 24.4 million, is expected to increase by 35% over the next 50 years, resulting in even more residents in long-term care facilities. These residents usually suffer from two or three chronic diseases,[2] 10% to 39% of them may be receiving antibiotics,[2-4] and 5% to 10% probably suffer from nosocomial infections.[5] This group probably has a higher than normal risk of acquiring nosocomial infections because of certain predisposing factors, such as immobility, urinary catheterization, aged immune systems, achlorhydria, poor oral hygiene, poor circulation, decreased pulmonary function, and malnutrition.

Non-typhoid salmonellosis is one of the leading causes of food-borne diarrhea.[6] *Salmonella* outbreaks in nursing homes have been reported and may account for as much as 8.7% of deaths in an outbreak.[7] Outbreaks caused by explosive single-point sources may affect more persons[8] than cross infections, which account for more outbreaks in nursing homes.[7] Serotypes associated with previous outbreaks in nursing homes have included *S saint-paul,*[9] *S derby,*[10] *S newport,*[11] and *S enteritidis.*[12] As many as 79% to 100% of



Longitudinal results of initial Salmonella-positive cultures during screening period. Residents 2 and 12 had positive cultures for S reading, *residents 5 and 13 for* S senftenberg, *and all others for* S heidelberg. *Cultures were positive from enrichment broth only in residents 6, 10, 11, and 12, with one colony each in 6, 11, and 12. Residents 1 through 4 were initially symptomatic; all others were asymptomatic. Symbols:* ● culture positive; ○ culture negative for Salmonella.

culture-positive persons in nursing homes may be asymptomatic carriers of *Salmonella.*[9-11]

Materials and methods

On May 7, 1985, in a nursing home caring for approximately 200 chronically ill elderly persons, a patient became ill during the evening with diarrhea and fever and was subsequently transferred to a local hospital. A *Salmonella* species was isolated in a stool specimen by the hospital laboratory. Two days later, a second resident of the home became ill with similar symptoms, and a stool specimen was submitted to a local commercial laboratory, which isolated a *Salmonella* species. These two *Salmonella* isolates were submitted to the City of Milwaukee Health Department Laboratory for biochemical confirmation and serotyping and were identified as *S heidelberg* and *S reading*, respectively. Subsequently, 143 patients and 63 staff members submitted stool cultures to the city health department. Those with positive stool cultures were recultured, when possible, until three negative cultures were obtained.

Stool specimens were submitted in clean cardboard containers and refrigerated until processed, not more than 24 hours later. Transport media were not used. Specimens were cultured, identified, and serotyped by previously described procedures.[13,14]

Results

Thirteen of 206 cultures (6.3%) were positive for *Salmonella;* serotypes were identified as *S heidelberg* (9), *S reading*(2), and *S senftenberg* (2), with one serotype per patient. Only four of those who had positive cultures (31%) —three residents and the one staff member—had diarrhea or fever (see Fig). The 13 persons were cultured over a range of 19 to 43 days, with two to ten cultures per patient. In six patients, only the initial culture was positive, while the other seven had positive cultures that remained positive over the following times in days: 9, 11, 21, 25, 26, and 37.

Antimicrobial susceptibility testing on all isolates was done by the disk diffusion method,[15] and all isolates were shown to be susceptible to ampicillin, amikacin, chloramphenicol, gentamicin, cephalothin, cefamandole, trimethoprim/sulfamethoxazole, tobramycin, moxalactam, and ticarcillin.

Between 1972 and 1985, the Milwaukee Health Department serotyped 2,881 human *Salmonella* isolates representing 106 different serotypes. The majority of the serotypes (74%) occurred less than seven times over the 14-year period. A minority of these serotypes (26%) accounted for 91%, or 2,609, of the total number of isolates. Of the three serotypes isolated in this nursing home, *S heidelberg* ranked second in the frequency of serotypes isolated in Milwaukee over the last 14 years, with *S reading* and *S senftenberg* 16th and 24th, respectively. These three strains ranked 2nd, 30th, and 34th nationally according to recent statistics from the Centers for Disease Control (CDC).[16] Interestingly, the CDC report noted that in non-human *Salmonella* isolates, 17 of 21 and three of three cultures taken from turkeys were positive for *S heidelberg* and *S reading,* respectively, and that *S senftenberg* was the third most common *Salmonella* serotype isolated from human food made from animal sources.

Discussion

Carriage and spread of Salmonella. Carriage of non-typhoid *Salmonella* may be relatively common and prolonged in nursing home residents.[9-11] One study reported on 36 asymptomatic residents who carried *S derby* for 11 months,[10] while another

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reported on a 35-day median carriage duration of *S saint-paul* for 45 persons, 80% of whom were asymptomatic, with one patient culture-positive for seven months.[9] In the latter study, patients excreting *Salmonella* were found in 31 of 39 rooms. In the present study eight of the 12 culture-positive residents (75%) were asymptomatic, with one person remaining culture positive throughout the survey for five cultures over a 37-day period.

It was not determined in this study whether the infection resulted from a point source or person-to-person spread; both have been described in nursing homes. For the period 1962 to 1973 the CDC reported that cross-infections accounted for the largest number of institutional *Salmonella* outbreaks, and they tended to spread among patients in a ward by person-to-person contact or by fomites.[7] Gotoff et al described an outbreak of *S saint-paul* that had characteristics of both types of spread,[9] with the initial cases resulting from contaminated food and subsequent cases from person-to-person spread.

Asymptomatic carriers probably play a role as sources of nosocomial infections in long-term care facilities. Surveillance of nosocomial infections, including *Salmonella,* however, can be difficult in nursing homes due to a higher percentage of nonprofessional staff, rapid turnover of employees, a low nurse-to-resident ratio, fewer laboratory and ancillary services, and less stringent infection control policies than may be found in hospitals. All of these factors may contribute to increased nosocomial infection.[5]

Culture and follow-up. In the interest of saving time and money, some researchers have questioned the need for enrichment broth in enteric stool cultures.[14,17] In this study, however, and in others,[9,10] the use of enrichment broth proved essential for recovering *Salmonella* from carriers. Gotoff et al[9] detected 17 additional *Salmonella* carriers from tetrathionate broth incubated at room temperature for 7 days, following a 48-hour incubation at 35 °C. These findings suggest that *Salmonella* is present in very small numbers in some individuals. We confirmed three cases by detecting only a single colony of *Salmonella* from a subculture of the enrichment broth, indicating that technical awareness and ability play a part in diagnosing some cases. Furthermore, the use of transport media in this study might have allowed detection of more positive cultures.

The recommended frequency of follow-up of two or three consecutive negative cultures at least one day apart proved to be adequate in this study.[6,18] Due to the erratic excretion and low concentration of *Salmonella* in some carriers, this frequency of culturing may miss some carriers, though probably infrequently. For example, McCall et al[10] reported one asymptomatic carrier in a nursing home that had four negative cultures over a two-month period between positive cultures.

Serotypes. More than 2,000 different serotypes of *Salmonella* have been described. Only 106 different *Salmonella* serotypes have been seen by our laboratory over the last 14 years, however. Seventy-four percent of these occurred less than seven times, and usually not more than two times, in any single year. Often, little immediate epidemiological significance can be placed on such random isolates. Two or more isolates of an unusual serotype identified over a short period of time, however, may prompt immediate telephone calls by the public health reference laboratory to the agencies submitting the cultures to determine the likelihood of a common source. For example, our laboratory recently received two samples (subsequently identified as *S kottbus*) for serotyping from two different agencies, which led to the discovery of 11 culture-positive patients in one nursing home. *S kottbus* is a relatively uncommon serotype in Milwaukee, identified only three times over the last 14 years, the most recent one being ten years before this incident.

Nursing home growth. Currently, there are 444 licensed nursing homes with a total of 52,499 beds in Wisconsin. Of these homes, one out of three has 200 or more beds, and four out of five are located outside of Milwaukee County—the most densely populated county in the state; 86% of nursing home residents in the state are 65 or older.[19] These facts illustrate the widespread rural distribution, relatively small size, and the elderly status of the residents of nursing homes in Wisconsin. It is, therefore, alarming to note that the number of persons over 65 and 85 is expected to increase by 119% and 206%, respectively, over the next 35 years.[1] As this population ages, long-term care will increase along with chronic illness,[20] and the carriage and spread of *Salmonella* will likely increase as well.

Continued monitoring of *Salmonella* carriage and salmonellosis in long-term care facilities will be required to halt the infection's spread and its resulting morbidity and mortality in this potentially susceptible and rapidly growing population. *Salmonella* reference laboratories will continue to serve as the first-line of detection for clusters or outbreaks of *Salmonella* infections in nursing homes and other institutions, especially when uncommon serotypes are detected.

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Trends in care for the elderly in geriatric psychiatry

Donald P. Hay, MD, Milwaukee

The field of geriatric psychiatry has grown rapidly over the past several years, spurred primarily by the exponential growth of the elderly population. The practice of geriatric psychiatry requires a knowledge of both the psychiatric and the medical disorders of the elderly, as well as their approriate treatment strategies. In this article, the author gives an overview of psychiatric problems that may be encountered by the primary care physician in elderly patients and outlines a practical strategy for treating them.

In part 1, which was adapted from a presentation before the medical staff of Columbia Hospital in Milwaukee in November 1987, Dr Hay discusses the changing medical environment and how it has affected treatment of the elderly. He also makes a plea for increased cooperation and sharing of knowledge between medicine and psychiatry and offers a practical guide in recognizing and treating these conditions. In part 2, which was adapted from a grand rounds presentation at Columbia Hospital in February 1988, the author offers strategies for improving the diagnosis and treatment of dementia, one of the most frightening and debilitating of illnesses for the elderly and their families.

"I grow old, I grow old, I shall wear the bottoms of my trousers rolled."

"Will you still need me, will you still feed me, when I'm sixty-four?"

T.S. Elliot and the Beatles both echoed the concerns of all of us with regard to aging. What changes will we go through? Will we need to be taken care of? If so, who will take care of us? What will life be like?

Over the past 20 years, physicians have witnessed significant changes in the population they serve. People in

this country are living longer, but their later years are frequently plagued with illness, poverty, and despair.

A paradox has resulted from the recent course of historical events: medical science and technology have taken us from an era of horse-and-buggy medicine to one of CAT scanners and laser beams—the technology is here, we can lessen illness and its effects in ways never before imagined—yet physicians, older patients, and society in general are more unhappy with one another than ever before.

While the past 20 years have brought tremendous advances in the health care of the elderly, they have also brought tremendous losses, for along with the technological advances has come an ever-increasing specialization and professional distancing of physicians from the *compleat* patient.

Horse-and-buggy doctors could not perform laser surgery, but they could sit with patients and their families and be their ombudsmen, their friends, and—indirectly—their psychiatrists.

Physicians used to be overly revered, sought after for advice and counsel in important matters of the day, and placed on a pedestal. The methods of healing were unknown by the populace, mainly because there were not many truly helpful methods beyond the inherent psychotherapy.

As medical technology advanced, the new methods of healing were made known to all: Drs Casey and Kildare, and others, made their way into everyone's home to explain the marvelous new developments in medical science. But with this new revelation came a change in the doctor-patient relationship.

With the methods of medicine elucidated on TV, as well as in every home companion medical guide, physicians were stripped of their mystique of mystery and knocked from their pedestal. Physicians were, and are, targeted as villains who purposefully created the tremendous health care cost increases associated with technological advances. Nowhere is this new relationship more apparent than with elderly patients. Physicians are often thought of as more interested in feathering their own nests than in helping their patients.

The lack of adequate reimbursement for health care for the elderly in hospitals, outpatient and home-care settings, and nursing homes is indeed a tragedy. Never have there been so many older patients with so much health care potentially available to them, but with so little emotional and financial support. And physicians are increasingly portrayed as the cause of the tragedy.

While all of this has been taking place, psychiatry too has changed. It emerged from the bedside interchange of the patient and horse-and-buggy doctor and developed into a more formal method of psychotherapy, which was then elevated to psychoanalysis by Freud. As a result, the gap widened between medicine—the applied science that developed strategies for treating the body, including the brain—and psychiatry—the science that developed insights for treating the mind.

With the relatively recent increases in knowledge of central nervous system neurotransmitters, the genetic transmission of psychiatric illnesses, such as schizophrenia, depression and manic-depressive disorder, and the development of treatments for these psychiatric illnesses, the gap between mind and body has narrowed considerably. To effectively treat their patients physicians and psychiatrists can no longer tolerate the mutually exclusive positions of either *mindlessness* or *brainlessness*.

It is now known, for instance, that among 65-year olds the incidence of biologic depressive disorder is essentially the same as that of dementia. And it is known that the syndrome of anxiety, insomnia, and depression, commonly experienced by the elderly, is often treated effectively with a low-dose antidepressant (with or without an anxiolytic) and usually with supportive psychotherapy.

With the body-mind division growing narrower, the medicine-psychiatry division will certainly need to narrow, especially in the treatment of the elderly.

No longer is it acceptable for some internists to just prescribe amitriptyline for the depressed elderly patient and then request a geriatric psychiatric consultation when the depression fails to clear. Neither is it acceptable for some psychiatrists to limit the evaluation and treatment of the elderly patient to psychodynamics without first examining the total medical work-up.

The internist needs to sit down with the patient and family and explore the issues surrounding the problems of the body. The psychiatrist needs to recognize the effects of beta blocker antihypertensives or hypothyroidism before pursuing the psychodynamics of dysthymic disorder or prescribing doxepin hydrochloride (Sinequan, Adapin).

On April 20, 1988, the first examination in geriatric medicine was administered in the United States. This exam was predicated on the awareness that medical care for the elderly is different from that for the young. It is going to come under the heading of added qualifications, rather than become another subspecialty, to allow all internists to continue to provide care for the elderly. A similar examination for added qualifications in geriatric care is being advocated in psychiatry.

These disciplines—geriatric medicine and geriatric psychiatry—will

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require a shared body of knowledge and set of skills of unprecedented proportions. And, contrary to the splitting off of pediatrics from medicine and of child psychiatry from psychiatry, these newer fields will encourage generalists to widen their bases of knowledge rather than refer problems to specialists.

The time seems right for this to occur. It is appropriate that physicians in the fields of medicine and psychiatry work closer together than ever before, sharing their knowledge bases, to treat the illnesses of body and mind—to treat the complete patient. Together they may be able to swing the pendulum back—never again to the point of physicians being revered, and never again to the point of being debased—but halfway back, to the proper respect for a cooperative venture to help society's aging population receive the medical and psychiatric treatment and support it deserves.

Geriatric psychiatry for the primary care physician

The following is a practical guide to the treatment of psychiatric symptoms commonly encountered in the elderly patient by the primary care physician. Discussion is limited to disorders requiring psychotherapy or psychotropic medication, or both, and to the factors determining when it is appropriate to refer the patient to a mental health professional.

While specific drugs are mentioned, the author recognizes that the use of medications is a matter of judgment, and that equally convincing arguments for using other combinations and dosages of psychotropic medications exist.

Depression, anxiety and insomnia. The most frequently encountered constellation of psychiatric symptoms is that revolving around the central symptom of depression. The problem with treating depression in our society is that the terms used to describe it are inadequate, imprecise, and unclear to both the general public and the medical profession. In fact, the term *depression* is woefully inadequate since it is a single word employed to describe a wide spectrum of so-called depressive disorders and, therefore, falls short of the mark.

The depressive disorders include situational sadness, or pure unhappiness, which is common enough in all of our lives, and responses to how our minds view particular events or situations. Retirement woes, marital discord, loneliness, and worry over real or imagined physical illness are but a few examples of what can lead to this type of depression.

The lonely widower, for example, may complain to his physician that he is able to carry on the usual and routine activities of daily living, but that the luster of life has disappeared. Being an event of the mind, this type of depression is subject to rapid improvement by a change of the patient's situation: the lonely widower meets an available widow, a despondent retiree is asked to work part-time at the local senior citizen center, etc.

At the other end of the spectrum of depressive disorders is what is called a major depressive disorder. This disorder is a dysfunction of the brain, a malfunction of neurochemical transmission, a physical, biochemical event. Theories abound as to why a person becomes biochemically blue—insufficient norepinephrine or serotonin at the synapse, excessive monoamine oxidase, etc. The symptoms, however, appear to be fairly universal and consistent.

The older patient, perhaps a widow, walks into the physician's office and almost immediately bursts into tears, then explains that she often cries without knowing why. She reports that she's only getting three or four hours of sleep and waking earlier in the morning than ever before—about 3 AM—and then can't get back to sleep. Her appetite has dropped off, and she's losing weight. She says that she fears she has developed a serious illness, but doesn't know what it might be.

In each of these scenarios, the patients exhibit their symptoms in a way that requires redefinition and explanation. The lonely widower who says he's fatigued and fears that he may have a serious illness needs to be reassured (after receiving negative results from a complete physical work-up) that all is well with his body and that the source of the problem lies within his mind. Brief psychotherapy may be useful, and the primary care physician may wish to enter into time-limited cognitive therapy written about by Pietro Castelnuovo-Tedesco in *The Twenty-Minute Hour: A Guide to Brief Psychotherapy for the Physician* (American Psychiatric Press, 1965). Or the physician may refer the patient to a local reputable psychiatrist for similar therapy.

The widow who is constantly crying, waking early, losing her appetite and weight, and suffering generalized anhedonia—but says "It's only depression, Doc, and I ought to be able to pull myself out of it. I don't want to bother anyone, it's my fault and I'll take care of it myself."—requires a different response.

This unfortunate stoic would greatly benefit from an adequate explanation of the major depressive disorder as a physical illness, not dissimilar to diabetes mellitus. This particular analogy can be very helpful when pointing out that, as with diabetes, this type of depression can be genetically predetermined and, as with diabetes, the onset of the symptoms can be sudden—often occurring after a precipitating event (eg, illness, surgery, severe emotional stress.) The patient needs to be told that there was nothing she could have done to prevent her disorder, that it is not a result of an inadequate life style or moral weakness.

Treatment of an elderly patient with a major depressive disorder usually consists of prescribing an antidepressant, the choice of which is best based on the medication's side effects.

Doxepin is an antidepressant that provides mild sedation in the patient with significant insomnia. This medication is relatively low in anticholinergic side effects and, therefore, tolerated well by most individuals. Dosages for the elderly range from as little as 10 mg, at bedtime, to 75 mg or even 100 mg, when necessary (the usual dose does not exceed 50 mg).

Anxiolytic agents are often prescribed for the anxiety and agitation that frequently accompany the symptoms of depression. Most typically, alprazolam (Xanax) is used because its short half-life makes it safer than diazepam or chlordiazepoxide, which have half-lives of 50 to 100 hours and can lead to increased confusion as metabolic break-down products accumulate. Lorazepam (Ativan) is also effective, but has recently been implicated as a benzodiazepine with a greater incidence of amnestic side effects.

For the patient already taking an anxiolytic during the day, the administration of a sedative-hypnotic is not recommended for sedation at night, which would result in the patient taking two benzodiazepines. Instead, the same benzodiazepine employed as an anxiolytic agent during the day can be used at bedtime, often in a slightly higher dose. This method is also helpful in preventing further confusion of the patient with multiple medications. One benzodiazepine employed as both an anxiolytic agent and a sedative-hypnotic is simpler than prescribing two.

L-tryptophan (Trofan) is recommended as a mild sedative-hypnotic which also can be taken during the day as an anxiolytic agent.

The combination of doxepin, alprazolam and L-tryptophan has become a trio frequently found to be both effective and relatively well tolerated by older patients.

What of amitriptyline hydrochloride (Elavil)? Employed frequently by primary care physicians, this is the medication the author most frequently suggests taking a patient off of; it has a propensity to induce a relatively high occurrence of anticholinergic side effects. Older patients, in particular, do not tolerate amitriptyline and frequently develop confusion and delirium, as well as urinary difficulties, tachycardia and other problems.

What about the depressed patient who has no difficulty sleeping—and perhaps even sleeps too much, night and day? This is often seen in post-stroke depression patients, many of whom are so sleepy that they cannot adequately participate in their rehabilitation program.

For these patients, the use of either low-dose desipramine hydrochloride (Norpramin) or very low-dose protriptyline hydrochloride (Vivactil) in the morning (bedtime doses tend to inhibit sleep) is usually effective.

Some patients on doxepin feel less depressed but rapidly gain weight. The solution is to discontinue the doxepin and place the patient on low-dose morning desipramine. These patients usually continue to have relief from the depression while gradually losing weight.

For the more serious cases of major depressive disorder, an anti-psychotic is often added, or a switch is made to electroconvulsive therapy (ECT) or an MAO inhibitor. Lithium is often used to treat manic-depressive disorder. Most often these cases are referred to the psychiatrist, however, and they will not be discussed here.

Confusion, agitation, and psychosis. For the confused and agitated elderly patient who must be tranquilized quickly, haloperidol (Haldol) is an excellent neuroleptic. It comes in a wide array of forms—tablet or liquid concentrate for oral administration, short-acting parenteral form, and long-acting intramuscular (IM) decanoate form. The parenteral form works quite well in low doses for the patient who can take nothing orally. In using this medication, physicians should be careful not to become too aggressive and give too much for too long. Inadvertent over-zealous haloperidol administration has produced acute dystonia (muscle tightness), akathisia (motor restlessness), akinesia (psychomotor retardation), and the typical parkinsonian triad of shuffling gait, pill-rolling of the upper extremity, and sialorrhea.

All of this can be avoided with a concurrent administration of an anticholinergic such as benztropine mesylate (Cogentin) in low dose.

Since haloperidol use is high in such extra pyramidal symptoms, a less potent neuroleptic, such as thiothixene (Navane), may be more practical. The addition of a sedating anti-psychotic at night, such as thioridazine (Mellaril), can minimize night time insomnia, restlessness and agitation (including "sundowner's syndrome").

General considerations

The following general guidelines are offered to aid the primary physician in recognizing and treating depression and other psychiatric disorders.

• In the same way that physicians watch for the warning signs of cancer, they should also consider the eight basic warning signs of biologic depressions: CEASE SAD

C Concentration decrease
E Early morning awakening
A Anxiety
S Suicidal thoughts
E Energy decrease

S Spontaneous crying
A Appetite changes
D Deprecating thoughts of self or feelings of guilt.

Be aware that so-called *atypical* depression may include several of the above items without the patients' recognizing that they are depressed.

• Reduce all doses of psychotropic medications to one third the adult dose when treating the elderly. Start low, then increase. For example, start doxepin or desipramine at just 10 mg daily, then work up gradually to a maximum of 50 mg. This will avoid significant side effects and lessen the

risk of the patient's discontinuing the medication. Be wary, however, of patients who reduce their medications to one third of the prescribed dose after the physician has already done so.

• Stay away from combination drugs such as chlordiazepoxide and amitriptyline HCl (Limbitrol) or perphenazine and amitriptyline HCl (Triavil). Getting two effects out of one pill may seem like a good idea, but these drugs pose a problem in that when doses are increased or decreased, two different drugs are affected at the same time.

With Limbitrol, it may be appropriate to adjust the dose of the antidepressant independent of the anxiolytic agent.

Librium, as noted earlier, has too long of a half-life for the elderly patient.

Triavil links a highly anticholinergic antidepressant (Elavil) with an antipsychotic (Trilafon). The latter may place the patient at risk for developing tardive dyskinesia. Avoid using any major tranquilizer except for psychosis—do not use these drugs as anxiolytic agents.

• Consider the elderly patient's potential for polypharmacy—a stockpiling of medications at home in the medicine cabinet and bureau drawers; also be aware of any over-the-counter preparations the patient is using that may contain belladonna alkaloids and interact synergistically with prescribed medications.

• Check for hidden alcohol use. The patient may have been drinking one or two cocktails at night for 30 years, but may no longer be able to, especially if he or she is taking multiple medications.

• Do not use meprobamate (Miltown or Equanil). There is no place for these potentially dangerous medications, which have therapeutic levels not far from the toxic level in an overdose.

• Always ask depressed patients about thoughts of suicide. Most patients expect their physician to ask about this and sometimes will not volunteer the information. Failing to ask this question in psychiatry is the same as failing to perform a rectal exam on a general medical patient.

• When in doubt—and when first meeting the patient—do not prescribe more than a week's supply of medications at a time; give weekly refills until the patient's next visit. More than a one week's supply of antidepressant medication may be lethal when taken as an overdose in a suicide attempt.

• Do not continue to change the type and dose amounts of psychotropic medications if the patient has been referred to the psychiatrist. Let the psychiatrist do that.

• Avoid beta blockers in patients with a potential for depression (most older patients).

Together, perhaps, medicine and psychiatry will be able to help the aging population such that the descendants of the Beatles will re-write the song to say: "Will you still need me, I hope I don't need you to feed me, when I'm 94."

* * *

Part 2: Dementia

In the past, it was generally accepted that as people aged they had a good chance of losing their faculties. This was not viewed as pathological, but as a natural consequence of normal aging. Individuals and families alike accepted it as a normal event. The word *senile* was accepted as describing the anticipated pathology of aging.

How different from today. Never have so many feared the loss of functional ability in later years. The effects of dementia in general, and Alzheimer's disease in particular, have been likened to an epidemic. Paradoxically, as a result of knowing that dementia is a pathological state not to be accepted as an inevitable consequence of aging, we are in some ways worse off than we were before. Where once *senility* was accepted as a household term, the public is now appropriately fearful of the prospect of developing a disorder for which there may be no cure.

But with the knowledge that dementias are in fact reversible—or that they may actually be the pseudodementia of depression, cognitive disruption from too many medications or other treatable conditions—more families are referring their aging relative to physicians for evaluation and treatment. It is, therefore, incumbent upon physicians to be as diligent as possible in assessing where they can be of assistance.

The following general considerations may be helpful in evaluating and treating elderly patients with symptoms of dementia.

Better mental status evaluations

The participants of a National Institute of Health Consensus Conference[1] recommended an accurate mental status evaluation of the patient to help identify treatable dementias. Far too frequently, physicians limit evaluations of patients' cognitive functions to a minimal and cursory assessment that provides little useful information and which may actually be quite incorrect and misleading.

Of particular concern is the common practice of employing questions of orientation as the sole test to determine a patient's mental status. Not only is this type of evaluation a poor discriminator of dementia (low sensitivity), but it is also subject to the artifact of over-learning through prior questioning by other members of the health care team.

A far better procedure is simply an expansion of the evaluation to include questions which assess attention and registration and recall. To assess attention, the physician could ask the patient to subtract seven from 100 and to spell the word *world* backward. For questions of registration and recall, the physician might name three items to the patient and check immediate recall, and then ask the patient to recite them again in five minutes to check on short-term memory. The combination of testing for orientation,

attention, and registration and recall provides a simple battery, which is easy to administer and relatively accurate in terms of sensitivity and specificity for evaluating cognitive function.[2]

Dementia *v* depression

At age 65, the incidence of dementia and depression is approximately the same (3% to 5%). This somewhat surprising statistic should serve to strengthen the physician's resolve to look for depression even when it is not readily apparent.

It is truly gratifying for the family, physician, and the rest of the health team to see a patient who is presumed to be demented respond and interact in a totally functional manner after being treated for a hidden or masked depression. Feinberg and Goodman[3] have written an excellent paper delineating four different syndromes that have symptoms of various mixtures of dementia and depressions.

When dementia and depression coexist, it is possible to treat the depression without enhancing the dementia. This is seen in the treatment of the early stages of Alzheimer's dementia; a major depressive disorder may be superimposed on the dementia and is treatable by traditional methods of antidepressant medication or ECT.

Similarly, patients with post-stroke mild dementia often exhibit a coexistent major depression, the extent of which may be correlated to the location of the brain lesion. Robinson[4] has studied this situation extensively and has found that left-hemispheric lesions have a much greater incidence of post-stroke depressive disorder than right-hemispheric lesions. He also found that the lesions more anterior in the left hemisphere have a greater incidence of depressive disorder than those located more occipitally.

Robinson also compared the use of nortriptyline hydrochloride with a placebo in the treatment of these post-stroke depressions and found the active agent to be significantly superior. The less sedating (and sometimes mildly activating) antidepressants such as desipramine and protriptyline have been found by the author, however, to be as good—if not better—than nortriptyline, since they seem to help the post-stroke depressed patient with decreased energy and initiative perk up and brighten up more rapidly.

One of the more frequent requests for a geriatric psychiatry consultation in the past few years has been to evaluate these individuals when they are withdrawn, essentially non-communicative and non-participatory in the post-stroke rehabilitation program. It is extremely gratifying to see such patients respond quickly to one of these antidepressant medications. It is important not to exceed the appropriate dose levels, as it is easy to overshoot the mark. With protriptyline, it is critical to prescribe the smallest amount possible (eg, 5 mg in the morning) and not to be tempted to increase the dose too quickly if the response is not immediate.

Murray[5] has reviewed a series of post-stroke depression individuals for whom ECT was administered and has shown that this treatment is another valuable and, at times preferable, treatment for those patients.

Memory disorders

Unfortunately, so much has been tried, and so little has been found to be helpful in treating memory disorders.

Of the cholinergic agents, the acetylcholine precursor lecithin has not been shown to be very effective in improving memory function. The anticholinesterases have been more effective, but they have problems of their own.

Physostigmine salicylate, although helpful in improving memory in some patients, has relatively short-lived effectiveness, making its use of questionable practicality.

Tetrahydroaminoacridine (THA) lasts longer, but some patients have developed liver function enzyme changes that have prompted researchers to switch to an analogue of the original drug being tested. This seems to be the single most promising substance currently under evaluation.

A host of other substances are being evaluated, including hydergine, the neuropeptides (ACTH, vasopressin, opioid antagonists, naloxone), and the cerebral metabolic enhancers or "nootropics." Although several seem to be promising, either alone or in combination, none appears to be as promising at this point as the THA derivative. Excellent articles reviewing this information have been written by Dysken[6] and Albert.[7]

Excessive medication

In the United States, the elderly are frequently over-medicated. The over-65 population, with its plethora of systemic ailments, has frequently built up a long list of multiple medications, which taken individually may have been very helpful but in combination may exert an effect on cognitive function that results in some form of an organic brain syndrome such as confusion, delirium or dementia. Larson[8] found that as the number of prescription medications increases, the odds of an adverse effect on cognition increases by 14 to 1 in a patient taking six or more drugs.

In the work-up of the patient being evaluated for a suspected dementia, physicians need to begin by removing any medications not absolutely necessary and lowering the doses of others. Doing so may result in a rapid reduction of symptoms and remove the necessity for a more extensive, expensive, and possibly unnecessary work-up.

Competency and consent

Not infrequently, there comes a time in the care of the elderly patient when a decision must be made about the appropriate degree of further medical intervention.

If the patient is suffering from multiple system disease, exhibiting

symptoms of depletion as well as dementia (and possible depression), it is extremely difficult to determine whether the patient's expressed wishes of limiting further medical intervention should be accepted as valid and truly representative of the actual intent. Often, such an individual has developed a cognitive dysfunction from multiple medications or an intercurrent major depressive disorder which predisposes them to faulty decision-making. As such, their wish to be allowed to die might be very different were they to be afforded the opportunity for treatment of the confusion, delirium, dementia or depression first.

Whenever there exists a possibility of organic brain syndrome or depression that may result in diminished capacity to make important decisions involving informed consent, therefore, an attempt should be made to diagnose and treat the underlying treatable problem—possibly with the assistance of a psychiatrist.[9-11]

With dementia, we have both lost and gained. We have lost the complacency that when one is so afflicted it is to be accepted as a natural consequence of aging, but we have gained the knowledge of a pathological process with which we may be able to intervene.

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Abstract

Fixed-tissue micrographic surgery for melanoma of the ear

Auricular melanoma poses two primary problems: eradicating the primary neoplasm and managing potential satellites; both must be solved without spilling the highly transplantable cells. A secondary problem is the need to spare the cartilaginous framework that gives shape to the ear. With fixed-tissue micrographic surgery, all incisions are made through fixed (killed) tissue as successive layers of tissue are conservatively removed for microscopic scanning of their undersurfaces by the systematic use of frozen sections. Because no incisions are made through live tissue, no melanoma cells are spilled during the excision of the neoplasm and its "silent" outgrowths. Satellites too small to be seen are not moved or disturbed and can be removed as they appear. The reliability of the method is indicated by a five-year cure rate of 75% in a series of 17 patients.

Frederic E. Mohs, MD, Department of Surgery, Mohs Surgery Clinic, University of Wisconsin Hospital and Clinics, Madison, Wisconsin.

Arch Otolaryngol Head Neck Surg 1988 (June) 114:625–631.■

Diet aid may contain prescription drugs

A mail order diet aid, advertised as a nutritional supplement, may actually contain prescription drugs, according to a letter in a recent issue of the *Journal of the American Medical Association.* Called Diennet (pronounced dee-en-ay), the diet aid is sold through the mail from France and is labelled as containing various fruit, herb and vegetable extracts, nutrients and other substances. Tests on three samples furnished to the authors, however, revealed that one contained therapeutic levels of diethylpropion and another contained both chlordiazepoxide and diazepam. The two researchers, one from Northwestern University Medical School in Chicago and the other with MetPath, Inc. of Wood Dale, Ill, reported their findings to the Food and Drug Administration and the Diennet supplier.■

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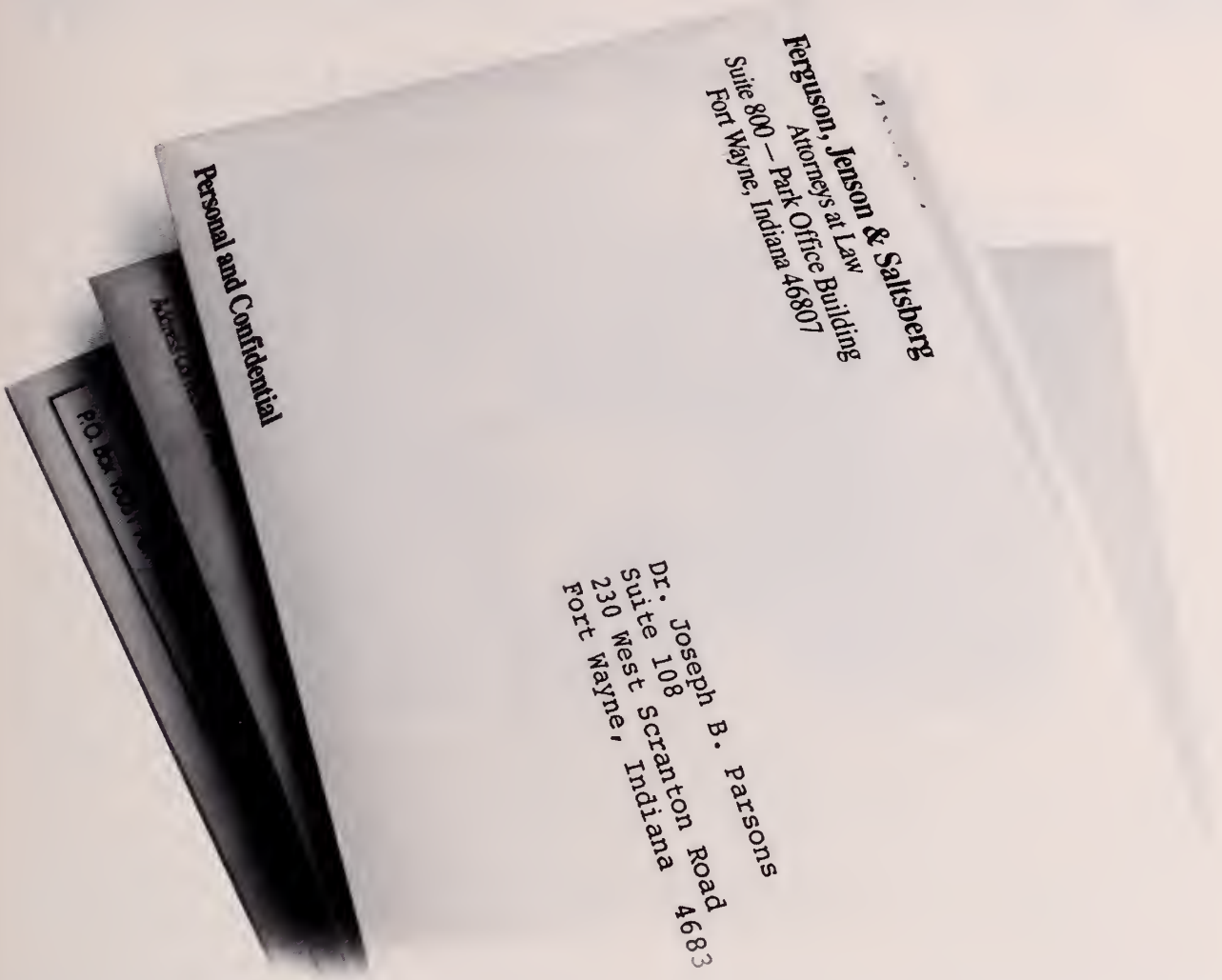

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Understanding managed care

William J. Maurer, MD, Marshfield

The medical care system is evolving. The familiar fee-for-service system had a loose organization of ambulatory and hospital services, home health care and long-term institutional care. Pharmaceutical services, durable medical goods and other ancillary services that require physician orders were usually paid for via a separate financing system. In contrast, modern health care is increasingly organized into comprehensive financing mechanisms such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) that unify all aspects of the health care system.

In this new unified environment, managed care can be defined as a comprehensive, unified health system organized by the patient's health care payer and emphasizing quality while minimizing cost. In a managed care system, physicians and managers of the health care payer's program prospectively focus attention on the optimum intervention needed. Evaluation of all aspects is made, including consideration of the type and frequency of care, as well as where the care is to be delivered. When quality is improved by elimination of duplication and unnecessary services, the patient benefits. Physicians and other providers are rewarded for their services and are made aware of appropriate levels of care as defined by their peers. The burden of increasing medical care costs to individual, business and government payers is relieved.

Compare this broad concept to the usual narrow image that arises when managed care is mentioned: individual case management by a utilization review nurse who is supervised by an administrative physician. Viewed this way, the major focus of managed care appears to be cost containment, accomplished by active review and intervention into the medical care. The leverage of denial of payment is used if the care does not meet a mutually agreeable level among the physician, patient, and nurse reviewer.

A key feature in the broader definition of managed care is the transfer of responsibility for the organization of health care from the patient's physician to those physicians and managers directing the financing. This shift of responsibility—and the growth of the managed care concept itself—is due to the financing of most medical care by some means other than direct payment by a patient to a physician. Medicare, Medicaid, third party payers, HMOs, PPOs and independent managed care organizations are the payers of health care for virtually all patients with health insurance. The exception is the ever increasing numbers of uninsured poor, near poor and others who, for various reasons, are neither eligible for government programs nor covered by some type of insurance program.

The financing of our health care system, growing more expensive yearly with ever increasing technology and an aging population, has required that medical care be scrutinized, organized and managed rather than simply paid for without question.

Understanding of the concept of a comprehensive unified health care system reveals hidden tools. Shifting the site of service from hospital to home, for instance, is sometimes better for the patient and can save health care dollars. A second opinion program can, at times, appropriately turn a surgical procedure into medical intervention. Other managed care tools include:

- Incentives and disincentives for providers.
- The establishment of appropriate care protocols.
- Claims review and audits.
- Buying "right"—for example, volume purchasing of supplies, the setting of maximum reimbursement levels for specific services, discounts, etc.
- Initial and periodic credentialing of providers to make sure they have the skills, training and attention to standards of quality care.
- Control of access to care and choice by patients in coordination with providers willing to play according to the rules of the managed care system.
- Streamlined coordination of benefits and subrogation issues. (Example: Making sure the primary payer (insurer) of the responsible party in a motor vehicle accident actually is held responsible for payment of the medical bills.)

Dr Maurer is the medical director of prepaid plans for the Marshfield Clinic. Reprint requests to: William J. Maurer, MD, Marshfield Clinic, 1000 N Oak Ave, Marshfield, WI 54449. Copyright 1988 by the State Medical Society of Wisconsin.

It should be apparent that the future of the medical care delivery system requires patients and providers to understand and accept a delivery system that will allow patients to get needed services, including expensive technology. This care must be high-quality care, delivered in the most cost-effective manner. Managed care, when conceptualized broadly, communicated appropriately and implemented optimumly, can be that system.

In summary, managed care is here to stay and has many tools, in spite of its common perception as a utilization review nurse second guessing a physician. Some decisions will be transferred to the managed care system, but the essential ingredient of medical care will remain the relationship between a well-trained, compassionate physician and a patient.■

Loss prevention

The physician's role in fueling liability fires

Michael C. Reineck, MD, West Bend

Of the many fuels feeding the fires of the current medical liability crisis, physicians are one of the most important—and underestimated—catalysts. The tinder is hottest when physicians are asked to review or critique a colleague's work, especially when called upon as expert witnesses for either the defense or the plaintiff.

Without the cooperation of a physician as an expert witness, it is extremely difficult for an attorney, no matter how capable, to prove malpractice. The courts are unlikely to determine that malpractice has occurred unless one physician testifies that the minimum standards of care were not met by another (except in res ipsa loquitur cases—for instance, leaving a sponge inside a patient). Most attorneys, before they accept medical liability cases, will make sure that the care rendered was, in fact, below the minimum standards—and not an acceptable minority treatment or difference in medical judgment. To do this, they need the help of knowledgeable, credible physicians, not merely hired guns or yes-men.

Physicians are also called upon to accept patients in transfer or to give second opinions regarding current and planned programs rendered by another physician. In so doing, physicians can profoundly affect the patients' opinions regarding quality of care that they have already received. If the second physician is overly or carelessly critical of the care provided by the first, a lawsuit may result.

Physicians, therefore, are key players in the liability drama and must accept responsibility for their role. As they accept responsibility, physicians can begin to take a more active role in bringing the crisis under control. When they give testimony regarding the standard of care, render a second opinion, or accept patients in transfer, they can reduce the likelihood of legal action by considering the following advice.

• Obtain complete records and x-rays before rendering an opinion.

Just as a patient's condition cannot be evaluated without a thorough examination and diagnostic studies, an evaluation of another physician's care program and thought process requires the possession of complete records and x-rays. Hastily drawn conclusions based on inadequate documentation are likely to be both incorrect and unfair to the prior treating physicians and their patients. The patient may not be justly compensated or the physician may be unjustly placed in jeopardy. A carefully formed opinion, based on complete medical records and x-rays, can help avoid both of these scenarios.

• Avoid casual remarks.

The physician-patient relationship is rooted in mutual trust and respect. In trying to establish this trust and respect, physicians often fall into the trap of making casual comments about prior treatment programs. Patients tend to analyze these comments and judge the standard of care received from the past physicians. If patients believe their care has been substandard, the trust and respect they held for their previous physician may rapidly be replaced with feelings of betrayal and anger. Quite simply, physicians must take greater care when commenting on past treatments, and should emphasize the positive aspects whenever possible.

• Temper criticism.

To better develop their skills, physicians are taught to be critical of their

Continued on page 34

Dr Reineck is a member of the SMS Medical Liability Committee and Risk Management Subcommittee. Copyright 1988 by the State Medical Society of Wisconsin.

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Continued from page 32.
own performance. They constantly compare the effectiveness of one treatment with another to find those they feel are the most effective for, and least hazardous to, their patients. Because these are often matters of judgment, physicians often identify strongly with their choices of treatment and, in so doing, may critically discount the alternatives. This criticism may be interpreted by nonphysicians as meaning that a particular treatment is substandard and that using such a program is the equivalent of malpractice. Physicians should, therefore, acknowledge to their patients that there are reasonable alternatives of care. Critical statements must be tempered so that they are based on scientific fact, not merely on a difference of opinion or judgment.

• Allow for practice variations.

The law usually recognizes there may be variations in practice patterns based upon locality. Physicians, however, are often intolerant of others who approach a problem from a different perspective. Most problems offer many paths to solution. Hindsight often reveals that one path may have been shorter or more effective than another, but this does not mean that the path taken was wrong. Criticisms should be reserved for substandard care based upon medical fact and not on differences in practice style.

• Be willing to testify and review cases.

Just as physicians are responsible to the public to help ensure that good care is rendered, they are responsible to their colleagues to help ensure that criticism of medical care is based on sound medical fact not a difference in judgment. To arrive at just solutions of medical liability trials, the courts need the reliable opinions of medical experts.

Many physicians, however, are unwilling to get involved, and they do a grave disservice both to plaintiffs and defendants. When plaintiff's attorneys are unable to find local medical experts to review cases and testify in court, they turn too often to the so-called hired gun. The testimony purchased from a hired gun is often a critical opinion leading toward a preconceived conclusion and resulting in the filing of a meritless but costly lawsuit. The defense of a professional liability action also rests on concise statements of the medical facts, so physicians are failing their colleagues if they are unwilling to review or render an opinion regarding the care provided.

• Be gentle to each other.

Physicians are often responsible for life-and-death decisions. Frequently, this burden may lead to the "MD-iety syndrome." It is in this state that physicians, by their excessive criticism of others, and by their attitude that no one can do it better than themselves, do the most harm. To counter this destructive attitude, physicians must foster within themselves, and encourage in their colleagues, especially students, the art of being gentle. This kind of attitude allows the many facts of a problem to be seen clearly, whereby statements based on medical facts—not differences in opinions or medical judgment—can be rendered.■

Electronic information in the medical office

William A. Yasnoff, MD, PhD
American Medical Association

Physicians have a continual need for information. This is a natural consequence of the overwhelming and increasing quantity of biomedical knowledge required for the practice of medicine today. Traditional sources of this information include colleagues, books, and journals, both in the hospital and office environment. Thanks in part to the decreasing cost of computer equipment, a new, low-cost, more up-to-date source of information is now readily available to physicians: electronic information.

Information received via computer may often be more convenient, more current, and more relevant than traditional sources. This article provides some examples of the types of electronic information which can be useful in addressing physician information needs. It focuses on AMA/NET, the AMA-sponsored nationwide medical information network which is now available to physicians throughout the United States.

Diagnostic problems

Probably the most common problem that physicians face is making a diagnosis. In the overwhelming majority of cases, the signs and symptoms of a patient's illness are clear and recognizable, and the diagnosis is rapidly made. There is, however, a small percentage of cases which present puzzling combinations of findings. It is in these cases that physicians traditionally seek the help of colleagues, books and the recent literature.

Colleagues, of course, are an excellent source of information, but they are not always readily available.

The usefulness of books is usually limited because the information in them is at least one year old, and is usually organized by disease, not signs and symptoms. A diagnostic hypothesis, therefore, must be formed before the information is accessible. Even books which focus on signs, symptoms, and differential diagnosis may not provide ready access to information relevant to a specific

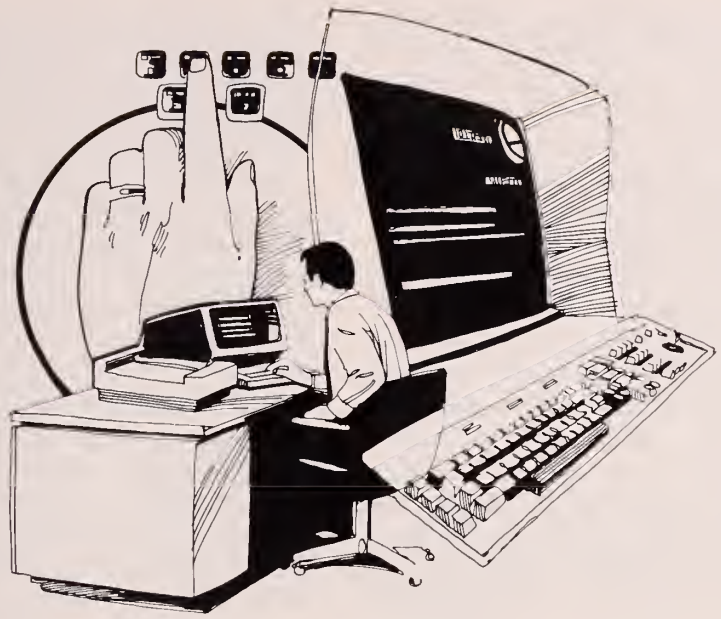
patient with an unusual combination of findings.

While the recent literature is more current than books, it is also organized by disease and is more difficult to access. Only a limited number of journals can be available in the physician's office. These are typically organized by chronology, and finding information on a particular topic may be quite time consuming. A well-organized and up-to-date reprint system may help compensate for these problems.

The nearest medical library will undoubtedly have a much more comprehensive collection of journals and also more capabilities for locating relevant articles (using, for example, the Index Medicus). The library, however, may also be inconvenient for the physician.

How can electronic information help? AMA/NET provides two types of information that can be of assistance in a diagnostic problem: 1) DxPlain, a diagnostic assistance program, and 2) various methods for searching and accessing the medical literature.

The DxPlain system is unique to AMA/NET; it provides patient-specific diagnostic information. Upon entering DxPlain, information is requested regarding the age and sex of the patient, duration of the problem and the signs, symptoms, and lab findings associated with this condition. This information is entered in a very natural form with opportunities for correcting spelling and other typographical errors. After entering all the information for the patient, DxPlain produces a list of diagnostic possibilities. This list is divided into common and rare diseases, and each disease shown is given a ranking according to the likelihood that it could be responsible for the observed patient signs and symptoms. DxPlain then will provide explanations describing those signs and symptoms that led to the inclusion of each diagnosis, other findings which are not explained, and additional findings which were not noted but would be expected in that particular condition. Thus, DxPlain can help the physician to both generate and think through the differential diagnosis in a puzzling case. It functions as a specialized, patient-specific differential diagnosis reference allowing rapid access to information which can be helpful in the diagnostic process.



Another important area where electronic information can be extremely useful is in search and retrieval of recent literature. AMA/NET provides several methods of accessing the medical literature. The first of these, is EMPIRES (Excerpta Medica Physicians Information Retrieval and Education Service), which indexes articles from 328 key clinical journals. Searching can be done in one of two ways: easy search and advanced search. In easy search, two key words are entered and a search is performed for all references which pertain to both those key words. An option is provided for restricting the search to the last six months. Very little (if any) knowledge with respect to searching techniques in databases is required to use each search. In advanced search, as many key words as desired may be entered, and combined in whatever way desired. Repeated searches can be done to narrow down the selections as needed. While advanced search is not difficult to use, it does require some knowledge of both searching techniques and the commands available. AMA/NET provides access to MEDLINE, the National Library of Medicine database of the world's biomedical literature, in two separate ways. First, access is provided by PaperChase, a friendly user interface developed at the Beth Israel Hospital in Boston. This program allows the physician with very little searching experience or knowledge of computers to construct a successful search of some complexity. Many physicians have found that it provides a fast and easy way to access the medical literature.

The National Library of Medicine's own user interface for MEDLINE, Grateful Med, is also available on AMA/NET. It provides a slightly different environment for helping the physician to develop and execute an appropriate search.

All three of these methodologies provide a useful way to access the most recent medical literature. Although the full text of articles found is not on-line for immediate reading, abstracts are available for the majority of the articles. Also, it is possible

to order paper copies of any articles retrieved (up to five EMPIRES articles per month are available at no charge).

Therapeutic problems

The physician's approach to a therapeutic problem is very similar to the diagnostic, although there are some sources of information which are more directly helpful. As with diagnostic problems, the traditional options available are colleagues, books, and literature. If information is desired on a specific drug or a class of drugs, this can be obtained from a number of references which are often readily available. However, the often-asked question regarding the determination of the currently accepted therapy for a given disease is sometimes more difficult. Here again, electronic access to the most recent literature can be very helpful.

One of the key words allowed in literature searching is "review." This results in the ability to access a recent review article on any given condition. This can often result in rapid identification of currently acceptable therapy.

Another common therapeutic problem is assessing the possibility of drug interactions, especially for a patient on many different medications. The MEDICOM drug interaction database recently became available on AMA/NET. It allows entry and storage of specific patient drug profiles so that patients with difficult drug interaction problems can be easily reevaluated when therapy is changed. In addition to drug interactions, drug-food, drug-nutrient, and drug-disease, and potential allergic reactions are also reported. Each reaction has an associated level of severity. If desired, output can be limited to the most clinically significant reactions. This avoids one of the classic problems in consulting printed drug interaction references: namely, the hundreds of interactions listed which have no practical clinical significance.

Next month: Obtaining the latest information on specific medical topics and finding references.■

Medicare: questions and answers

Q. When I bill for multiple surgeries performed on the same day, how does Medicare determine my reimbursement?

A. The major surgery is paid at 80% of the full approved amount and the second surgery is paid at 80% of half of the approved amount. Medicare uses the 1974 California Relative Value Scale or their Medical Advisors to determine the base value or units. The surgery with the higher base value is considered the major surgery.

Q. Should I use an 80 modifier when I submit charges for assisting at surgery?

A. The 80 modifier is not recognized by Medicare because the type of service 8 (assistant surgeon) describes the service. This situation applies to other modifiers also. For example, the type of service F should be used in place of the 26 modifier to bill for professional services. Always check to see if a type of service code will adequately describe your service before using a modifier.

Q. I am confused about billing for services provided by a physician assistant in the office. What does Medicare require on the claim form?

A. When billing for services provided by a physician assistant in the office, you must meet "incident to" requirements. The claim form should include the NP modifier, the physician assistant's name and title directly under the description of service in box 24c and the physician's name, address and provider number in box 31. These instructions apply to all services provided by non-physicians in the office. "Incident to" guidelines, however, apply only to physician's personal professional services, and therefore do

Medicare mess kits available

A "Medicare Mess Kit" designed to help senior citizens organize their medical bills—whether Medicare or health insurance claims or out-of-pocket expenses—is available from the Coalition of Wisconsin Aging Groups. The kit includes a heavy-duty, expandable folder with pockets for filing pending and paid claims and payments, a 46-page publication that explains the health care payment system and offers problem solving tips, a special supplement detailing recent changes in Medicare coverage (including the new catastrophic coverage), a guide to health maintenance organizations in Wisconsin, and an information sheet about PartnerCare.

The price for the kit is $15 for persons who belong to Coalition member groups and $18 for non-members, plus $2 for postage and handling. For more information about the kit, contact the Coalition of Wisconsin Aging Groups at 1245 E Washington Ave, Suite 166, Madison, WI 53703; phone: 608-257-0023.■

not apply to services such as a nurse giving an injection or the drawing of a lab.

Q. It seems that I am always receiving concurrent care denials from Medicare. Can you explain how Medicare determines when to deny a claim as concurrent care?

A. There are two types of concurrent care, one is medical concurrent care (no surgery is involved) and the other is surgical concurrent care. The admitting physician is considered the primary physician in medical concurrent care situations and the surgeon is primary in the case of surgical concurrent care. In both cases, Medicare reviews the patient's condition in addition to the physician's specialty to determine whether the primary physician could care for the patient solely. Listed below are tips for billing concurrent care:

1. Always list a complete diagnosis and try to get all information on the claim form instead of sending attachments. If you must send hospital records, make sure the patient's name and health insurance number is given on each form.
2. Concurrent care may be approved if the patient's condition is acute rather than chronic. For example, a diagnosis of diabetes would not justify the care of two physicians. The diagnosis of uncontrolled diabetes post-operatively, however, may justify concurrent care.
3. Medicare compares specialties when determining whether to approve concurrent care. If you have a sub-specialty, list it on the claim form.
4. Medicare will not approve coverage for one physician of the same specialty to cover for another physician over the weekend. If the primary physician goes on vacation (3 or more days) let Medicare know you are assuming total care of the patient by documenting this on your claim.

Q. Is the order in which the patient's diagnosis is listed on the claim form a factor in approving concurrent care?

A. No, the diagnoses do not need to be in any particular order. Put as much information as you can in box 23 of the claim form. It is much easier for Medicare's claims processors to pick up information on the claim form than from an operative report or hospital records.

Q. What is Medicare's outpatient psychiatric limit?

A. Medicare's outpatient psychiatric limit is the lessor of 62.5% of the reasonable charge or a fixed dollar amount as follows: $312.50 in any year before 1988, $562.50 in 1988, and $1,375 in any year after 1988. These amounts represent 62.5% respectively of $500, $900, and $2,200. These are the maximum reasonable charges for outpatient psychiatric services.

Questions for this column should be sent to Medicare Q&A, c/o Karen Lord, State Medical Society of Wisconsin, PO Box 1109, Madison, WI 53701.■

Professional licenses and AIDS

State licensing boards may not enact general regulations that would suspend, deny or revoke the licenses of persons with communicable diseases—including AIDS, Attorney General Donald J. Hanaway has ruled. The opinion (OAG 51–88), which was released in September, was in response to an inquiry by Marlene Cummings, secretary of the Department of Regulation and Licensing.

Hanaway also said that while licensing boards may not enact *general* regulations preventing a person with a communicable disease from practicing his or her profession, they may, on a case-by-case basis, restrict the license of a person who poses a direct threat to the health and safety of other persons or is unable to perform his or her duties.

The SMS has called the opinion "both a legally sound and medically appropriate response" to Cummings's inquiry.■

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Medical Writing Contest

The annual Wisconsin Medical Journal Medical Writing Contest was created by the State Medical Society in 1987 to introduce young and future physicians to the importance of scientific publishing and to recognize the best and the brightest among Wisconsin's residents and medical students. The complete rules are listed below. Non-winning papers are also considered for publication in the Scientific section of the *Wisconsin Medical Journal.*

Awards $500, publication in the *Wisconsin Medical Journal,* and recognition at the Annual Meeting of the State Medical Society. Two awards presented: one for a student paper and one for a resident paper.

Sponsor The *Wisconsin Medical Journal,* official publication of the State Medical Society of Wisconsin.

Eligibility Contestants must be either a student enrolled at either of Wisconsin's medical schools or a resident actively training in Wisconsin.

Deadline Entries must be received by the *Wisconsin Medical Journal* no later than Jan. 31, 1989: PO BOX 1109, Madison, WI 53701.

Rules

- Topics must fall within the parameters of scientific medicine: clinical, case report, research or review.
- Papers must be original, unpublished, and credited to one author (although multiple authors may be listed).
- Length: 10 pages, typewritten, and double-spaced with 1-inch margins.
- Illustrations are encouraged, but must be included in the 10-page length limit.
- The Editorial Board of the *Wisconsin Medical Journal* serves as the panel of judges and has final authority.

Criteria

- *Scientific merit:* research methods, data analysis, subject or patient population selection, control of variables, and literature analysis.
- *Applicability:* usefulness of results to private practitioners, academicians or researchers.
- *Content:* depth of analysis, continuity of discussion supporting thesis, and feasibility of conclusions.
- *Innovation:* uniqueness of idea, creativity, improvement of existing techniques, discovery of new data, or advancement of basic understanding.
- *Writing:* clarity and organization.

Board targets tort reform in 1989–90

The SMS Board of Directors, at its meeting held in conjunction with the recent SMS Leadership Conference in Oshkosh, Oct 22, renewed its commitment to achieving meaningful reform of the tort system during the upcoming legislative session and discussed strategies for reaching this goal.

Terry Hottenroth, director of the Division of Public Affairs and the lead lobbyist for the SMS, told board members that, due to the revitalization of the Coalition for Civil Justice and the general political atmosphere, the climate for seeking tort reform during the 1989–90 legislative session has improved.

In August, the coalition hired Maurice Bishea as its full-time executive director and retained a lobbying firm to work for passage of tort reform legislation mainly in three areas: changes in joint and several liability provisions, a cap of $250,000 for non-economic damages in medical malpractice actions, and changes in product liability statutes. The coalition then launched an advertising campaign in October to open its 1989–90 drive for liability law reform. The advertising is intended to build grassroots support for tort reform measures before the Wisconsin legislature begins its next session in January. The coalition is made up of more than 100 state organizations, including the SMS.

"We think most citizens are fed up with the 'sue you' climate that has settled in our state," Bishea said, "yet they have felt powerless to do anything about it. The ad campaign is designed to let them know they don't have to stand for it and that they can have a direct role with us in effecting change if they choose."

The campaign includes a toll-free telephone number, 1-800-444-2161, by which citizens can voice their opinions, receive additional information, and describe their personal experiences with Wisconsin's liability law.

Meanwhile, the SMS has retained former state representative Bill Broydrick to lobby on behalf of the $250,000 cap on noneconomic damages.

Hottenroth also discussed legislative strategies for achieving tort reform. She said SMS staff will be identifying key legislators and allies on the issue, building coalitions of supporters, engaging in energetic lobbying of legislators, and helping physicians communicate with their legislators about the issue. Ron Henrichs, director of the Division of Communications, outlined a year-long communications strategy that would complement SMS legislative activity. The communications plan will use news releases, patient education brochures, news conferences, speeches, and advertising to educate patients and the public in general about the need to reform the tort system in Wisconsin.

In other action, the board:

- Endorsed a recommendation from the SMS Task Force on AIDS supporting seroprevalence studies on HIV infection in Wisconsin;
- Voted to support the AMA's revised statement on euthanasia (the main change being that physicians should not be held legally liable for following the AMA's guidelines and that information regarding a patient's terminal illness should be protected from public scrutiny);
- Agreed to accept a change in rules relating to the hospital administration of oxytocics proposed by the Wisconsin Association for Perinatal Care—with the addition of language proposed by the SMS Committee on Maternal and Child Health specifying that standing orders for a nursing protocol allowing the nurse to dose the oxytocin drip would have to be approved by the hospital's medical staff or department of obstetrics;
- Endorsed the idea of a special issue AIDS awareness postage stamp, as proposed by a Madison nurse;
- Approved undertaking a statewide survey of members to gather demographic and practice data about the medical profession in Wisconsin;
- Discussed plans for the celebration of the SMS's 150th anniversary;
- Heard updates from various SMS task forces and committees about recent activities.■

News highlights

The Marshfield Medical Research Foundation was recently awarded a grant of $202,747 by the US Dept of Health and Human Services. The grant was part of a $1 million award to five rural health research centers for gathering data on a wide range of rural health care issues.

Adams County Memorial Hospital recently announced that Tom Galarowicz of Ladysmith has been named assistant administrator of fiscal services. Galarowicz had been director of finance of Rusk County Memorial Hospital and Nursing Home.

The first Raymond E. Whitsitt Memorial Lecture was held in November at Meriter–Madison General Hospital in Madison. The featured speaker was Edward J. Quilligan, dean and professor of obstetrics and gynecology at the University of California in Irvine. The topic of his presentation was "Can We Reduce Cerebral Palsy?" Also on the program were C. Robert Jackson, MD,* and Klaus D. Diem, MD,* both of Madison and former partners of Dr Whitsitt, and Russell F. Lewis, MD,* also of Madison.

David L. Larson, MD,* was recently appointed clinical director of North Central Health Care Facilities in Wausau. Dr Larson has been a staff psychiatrist with North Central for the past eight years.■

AMA Awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

September 1988

*Bernhardt, Louis C., Madison
Cullen, Gerald M., Milwaukee
*Domnitz, Jeffrey M., Milwaukee
*Finesilver, Alan G., Green Bay
*Frechette, Paul F., Janesville
Geske, David L., La Crosse
*Hanson, William R., Eau Claire
*Lewinnek, Walter, Merrill
*Mattingly, William T., Wausau
*Patel, Munikumar H., Milwaukee
*Raduege, William E., Woodruff
Steiger, Fredric A., Milwaukee
*Tang, Thomas T., Milwaukee
*Tompkins, Douglas G., La Crosse
*Weeth, John B., La Crosse
*Yousif, N. John, Elm Grove■

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Leadership conference proves lively

Nearly 150 physicians and their spouses gathered for the SMS Leadership Conference in Oshkosh Oct 22 to hear and participate in lively and thought-provoking discussions on issues affecting the practice of medicine and the quality of health care in Wisconsin.

A highlight of the conference was a debate during the afternoon between J D Kabler, MD, SMS president, and Bonnie Allbaugh, RN, president of the Wisconsin Nurses Association (WNA), on the merits of the registered care technologist (RCT). The RCT proposal, endorsed by the AMA at its annual meeting in July, would create a new level of health-care worker to perform routine patient care in hospitals and long-term care facilities. The AMA has called for the implementation of pilot programs to test the proposal. It is vigorously opposed by nursing groups, including the WNA, which argue that the creation of a new level of worker would further fragment patient care and that RCTs would not receive adequate training.

During the frank, but friendly, debate, several members of the audience stepped up to the microphone to voice their opinions about the proposal and nursing issues in general. Dr Kabler appeared to sum up the feelings of many in the audience when he said nursing and physician groups—such as the SMS and the WNA—must continue to communicate their concerns to each other and must work together in solving the nursing shortage.

SMS Leadership Conference: (left to right) Robert F. Purtell, Jr, MD; John K. Scott, MD; Frank H. Urban, MD, Thomas L. Adams, Terry Hottenroth, and Timothy T. Flaherty, MD.

Also during the conference, Daniel Wikler, PhD, of Madison, and Gwendolyn Bedford of Phoenix, Ariz, representing the American Association of Retired Persons (AARP), discussed the issue of setting limits on providing health care to the elderly. Bedford called the idea "threatening" to elderly groups and said chronological age should not be the sole criterion for making such decisions. Wikler challenged the notion that the United States can no longer afford to provide unlimited health care to all those who need it. He also argued that continuing increases in the price of health care do not appear to be inevitable.

Participants also heard presentations on the Harvard resource-based relative value scale (RBRVS)—proposed as a new physician reimbursement system under Medicare, and updates on ongoing SMS activities in the areas of PartnerCare, tort reform (see accompanying story), health care for the uninsured, legislation, AIDS, and the AMA.■

Report of the Task Force on Physician Review and Discipline

The SMS Task Force on Physician Review and Discipline met on July 8, 1988, to examine the extent to which its 1986 recommendations had been adopted by the Wisconsin legislature, the Department of Regulation and Licensing (DRL), and the Medical Examining Board (MEB), and to determine whether any changes had occurred in physician review and discipline. At the July 30, 1988, meeting of the SMS Board of Directors, the task force made the following report and recommendations.

The task force found that, with regard to physician discipline, DRL Secretary Marlene Cummings has adopted few of the 1986 recommendations and has, in fact, moved the DRL further away from independence for the MEB and toward centralization of the DRL staff. Cummings has attempted to improve the DRL's performance in investigating and prosecuting complaints brought against licensees by instituting a series of management changes aimed at improving accountability through role definition and better staff supervision. The DRL and MEB have initiated several new disciplinary functions, including settlement conferences and remedial continuing medical education. The DRL and MEB also sought to improve existing

Continued on page 45

Soldier being examined for effects of high-altitude cerebral edema.

ALLAN J. HAMILTON, M.D.

Neurosurgical Resident and Research Fellow, Massachusetts General Hospital, Boston, Massachusetts. Captain, U.S. Army Reserve.

EDUCATION Ithaca College, B.A. (Magna Cum Laude); Hamilton College (Pre-med); Harvard Medical School.

RESIDENCY General Surgical Internship. Neurosurgical Residency, Massachusetts General Hospital.

CONTINUING EDUCATION Neurology and Neurosurgery Research Fellowship Training, National Institutes of Health.

OUTSTANDING ACHIEVEMENTS Olsen Memorial Fellowship, National Masonic Medical Research Foundation; Albert Schweitzer Fellowship, International Albert Schweitzer Foundation; Harvard Medical School Cabot Prize for Best Senior Thesis; recently published article, "Who Shall Live and Who Shall Die" in Newsweek Magazine.

"The work I'm doing in the Army Reserve fits perfectly with my academic research interests in civilian life. The Army is very concerned with the effects of high-altitude cerebral edema, which is a mirror model of cerebral hypoxia, something I deal with every day in our neurosurgical intensive care unit. I couldn't ask for a smoother transition. And that's true for a lot of Reserve physicians. All we really do is change our clothes, not our mindset.

"Some of the projects the Army is undertaking are on the cutting edge of research. For example, I'm currently involved in developing for the Army a prototype of a non-invasive intracranial pressure-monitoring device that we hope will allow us to measure pressure changes as the brain swells—without drilling holes in the skull. If we can get our design to work, such a device could revolutionize high-altitude medicine as well as civilian neurosurgical care.

"The quality of medicine and the caliber of people I've been associated with in the Army Reserve are, without question, equal to civilian hospitals. In fact, I'm giving serious consideration to applying for an active duty academic position in Army Medicine when my residency ends at Massachusetts General."

Find out more about the medical opportunities in the Army Reserve. Call toll free 1-800-USA-ARMY.

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Summary.
Consult the package literature for prescribing information.

Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae, Haemophilus influenzae,* and *Streptococcus pyogenes* (group A β-hemolytic streptococci).
Contraindication: Known allergy to cephalosporins
Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:
- Discontinue Ceclor in the event of allergic reactions to it
- Prolonged use may result in overgrowth of nonsusceptible organisms
- Positive direct Coombs' tests have been reported during treatment with cephalosporins
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include
- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever): 1.5%, usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia

Abnormalities in laboratory results of uncertain etiology
- Slight elevations in hepatic enzymes
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis, elevations in BUN or serum creatinine.
- Positive direct Coombs' test
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly).

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Continued from page 42
functions by promulgating new summary suspension procedures, refining the complaint priority ranking system, and implementing an independent computer system.

Despite these efforts, the task force found that problems remain in the relationship between the DRL and the MEB, the MEB's ability to use its disciplinary powers, the MEB's performance in disciplining physicians, and the DRL's efficiency in investigating and prosecuting complaints.

Concerning physician review, the task force concluded that the peer review environment is perceived by physicians to be more hostile, and for good reason. The affect of the US Supreme Court's decision in *Patrick v Burget* cannot yet be measured.

The Task Force on Physician Review and Discipline recommended to the SMS Board of Directors:

- The SMS should request that the DRL provide it with comprehensive data concerning the MEB's performance in disciplining Wisconsin physicians from 1986 to the present, with a deadline for receipt of this information.
- The Task Force on Physician Review and Discipline should be reactivated to evaluate this DRL data when it becomes available.
- The MEB should be given greater disciplinary flexibility as originally recommended and the means, both legal and staff, to use this disciplinary authority.
- The Remedial Continuing Medical Education Program, developed by the University of Wisconsin School of Medicine and Medical College of Wisconsin, should be supported for use by private review organizations, such as hospital medical staff committees, and to a limited extent by the MEB, provided that general as well as focal competence can be adequately evaluated.

For further information, or for copies of either the task force's 1986 recommendations or complete 1988 report, contact Sally Wencel, Staff Attorney, State Medical Society of Wisconsin, PO Box 1109, Madison, WI 53701; or call 1-800-362-9080 or 608-257-6781.■

Physicians briefs

John L. Melvin, MD,* of Milwaukee, received the American Congress of Rehabilitation Medicine Gold Key Award at the group's annual meeting in November. Dr Melvin received his degree from Ohio State University Medical School and served his residency at the Ohio State University Hospitals. He is agency medical director of the Curative Rehabilitation Center and professor and chairman of the Department of Physical Medicine and Rehabilitation of the Medical College of Wisconsin. The Gold Key Award is given annually to a health care professional or lay person who has provided extraordinary service in the field of rehabilitation medicine.

Vanee Songsiridej, MD,* of La Crosse, was recently elected to the board of directors of the American Lung Association of Wisconsin. An internist and allergist at Gundersen Clinic in La Crosse, Dr Songsiridej attended medical school in Bangkok, Thailand.

J. Frank Wilson, MD,* of Milwaukee, was recently named a fellow of the American College of Radiology. He received his medical degree from the University of Missouri at Columbia and served an internship with the US Public Health Service in New Orleans. He served residencies at Penrose Cancer Hospital in Colorado Springs, Colo, and at the National Cancer Institute in Bethesda, Md. Fellowships in the American College of Radiology are awarded for significant scientific or clinical research in the field of radiology and for important contributions to the literature.

Kenneth I. Gold, MD,* of Beloit, recently received the 1988 Distinguished Internist Award from the Wisconsin Society of Internal Medicine. Dr Gold, who is with the Beloit Clinic, received his medical degree from the State University of New York–Brooklyn and served an internship and residency at University Hospitals in Columbus, Ohio. He is a past president of the Wisconsin Society of Internal Medicine.

Amy Leigh Johnson, MD,* and **David M. Johnson, MD,*** recently joined the staff of the Monroe Clinic. A pediatrician, Dr Amy Johnson received her degree from the University of Wisconsin Medical School and completed a residency at the University of Tennessee Le Bonheur Children's Medical Center. She was previously a clinical instructor in pediatrics at the Medical College of Wisconsin and at Mt Sinai Medical Center in Milwaukee. Dr David Johnson earned his degree from the Medical College of Wisconsin and served an internship at the University of Tennessee–Memphis, where he also completed a residency in internal medicine.

Larry A. Lindesmith, MD,* of La Crosse, was recently named the 1988 recipient of the American Lung Association of Wisconsin Distinguished

Service Award. He received the award for service to the association and for the treatment of patients with pulmonary disease. Dr Lindesmith is with the Gundersen Clinic.

James Holzberger, MD, recently joined the Marshfield Clinic. An ophthalmologist, Dr Holzberger received his degree from the University of Wisconsin Medical School and served residencies at Henry Ford Hospital in Detroit and the Marshfield Clinic.

Joseph Golubski, DO, has joined the medical staff of Sheboygan Memorial Medical Center. A pathologist, Dr Golubski received his degree from the Kansas City College of Osteopathic Medicine and completed an internship at Brentwood Hospital in Warrensville, Ohio. He served a residency at the Naval Regional Medical Center in Portsmouth, Va.

Ralph P. Bennett, MD,* recently retired after 36 years of practice in the Ladysmith area. He received his degree from the University of Wisconsin Medical School in Madison and served an internship at the University of Kansas Hospital in Kansas City.

Geoffrey Coleman, MD, recently joined the medical staff of the Menominee Tribal Clinic. Dr Coleman graduated from Temple University School of Medicine in Philadelphia and completed a residency at Jackson Park Medical Center in Chicago.

Scott D. Glazer, MD, and **Keith M. Kozeny, MD,** recently formed Kenosha Dermatology Associates. Dr Glazer received his medical degree from Northwestern University and was in private practice in Chicago. Dr Kozeny received his medical degree from Loyola University in Chicago.

Debra A. Strodthoff, MD,* recently joined the staff at Family Medical Clinic in Amery. A family physician, Dr Strodthoff received her degree from the University of Wisconsin Medical School and served a residency with the University of Wisconsin–Eau Claire family practice residency program.

Carol A. Larson, MD,* recently joined the staff of Marshfield Clinic. A psychiatrist, Dr Larson received her degree from the University of Minnesota Medical School and completed a residency at University of Minnesota Affiliated Hospitals. She previously was on the staff of an outpatient psychiatric facility in Princeton, WVa.

Albert J. Musa, MD,* recently joined the staff at Monona Grove Clinic in Monona. A specialist in internal medicine and family practice, Dr Musa graduated from Rush Medical College in Chicago and completed an internship and residencies at the University of Wisconsin Medical School.

Nunilo L. Bugarin, MD,* of Tomahawk, recently received the Partner in Health award from the Sacred Heart Hospital Foundation during the fifth annual foundation dinner. Dr Bugarin has practiced medicine in the Tomahawk area since 1967, when he helped establish the Family Clinic, which merged with the Rhinelander Medical Center in 1987 to become the Tomahawk Medical Center. He is a past president of the Sacred Heart Hospital medical staff and the Lincoln County Medical Society.■

County society news

Dane. The Dane County Medical Society recently held its annual meeting and the following physicians took office: Dolores A. Buchler, MD,* president; Thomas H. Browning, MD,* president elect; Bradley L. Manning, MD,* vice president, and Susan M. Haack, MD,* secretary-treasurer. Also, Dr Robert A. McDonald* received the Presidential Award in recognition of his faithful service in the society's legislative activities, and Dr William E. Scheckler* received the Board of Trustees Award for his exceptional service to Dane County citizens through his efforts in the area of public health.

Oneida-Vilas. Peter J. Hauri, MD, of Rochester, Minn, was the guest speaker at the Oneida-Vilas County Medical Society meeting in September. Dr Hauri's speech was entitled "The diagnosis and treatment of insomnia." Drs Kathleen L. Barkow* and Steven L. Kidd,* both of Rhinelander, were accepted to membership.

Outagamie. Sixteen members were present at the Outagamie County Medical Society to hear guest speaker Mary Lou Robinson, an attorney, speak on medical malpractice lawsuits. The new officers for 1988–89 were introduced: Drs Robert L. Hausserman,* president; Charles N. Kagen,* vice president, and Peter V. Podlusky,* secretary-treasurer. Stephen C. Dungar, MD,* of Appleton, was admitted to membership in the society.

Winnebago. Thirty-two members were present at the Winnebago County Medical Society to hear John S. Toussaint, MD,* of Neenah, speak on "National cholesteral education program: Physicians update." Drs Bruce Abrams,* of Neenah; David E. Coleman,* of Oshkosh; and Kenneth Erdmann,* of Winnebago, were accepted to membership.■

Specialty society news

The **Wisconsin Society of Internal Medicine** recently installed Susan L. Turney, MD, of Marshfield, as president of the society at the 33rd annual meeting held in Milwaukee. She succeeds Cyril M. Hetsko, MD, of Madison. Dr Turney was elected to the WSIM Council in 1985. She held the post of secretary-treasurer in 1986 and president-elect in 1987. Dr Turney graduated from the University of Wisconsin Medical School, Madison, and served her residency at the Marshfield Clinic. Other officers announced include William J. Listwan, MD, of West Bend, president-elect, and Robert E. Phillips, MD, of Marshfield, secretary-treasurer. Thomas E. Looze, MD, of West Bend, and Daniel T. Peterson, MD, of Janesville, were elected to three-year terms on the WSIM Governing Council. Steven B. Greenman, MD, of Milwaukee, was elected to the Council to fill the unexpired term of William J. Listwan, MD, and James L. Algiers, MD, of Hartford, was re-elected to a second term. Other members of the council are MDs Michael P. Dailey, MD, of Menomonee Falls, Richard A. Dart, MD, of Marshfield, and Bruce A. Kraus, MD, of Columbus.

The **Milwaukee Ophthalmological Society** recently announced its new officers for the year 1988–89. They are: Gregory P. Kwasny, MD, president; Gary W. Abrams, MD, vice president; Richard D. Davenport, MD, secretary, and Larkin Allen, DO, treasurer.

Obituaries

Dean L. Martalock, MD, 55, of Stoddard, died Sept 6, 1988, in Stoddard. Born July 26, 1933, in Monroe County, Dr Martalock graduated from the University of Wisconsin Medical School, Madison, and served his internship at La Crosse Lutheran Hospital. Dr Martalock completed his residency in dermatology at the Mayo Clinic in Rochester, Minn. He served in the US Naval Medical Corps from 1970–1972, and joined the Skemp Clinic, Ltd, after service. He also had been a member of the St Francis Medical Center since 1972. He was a member of the La Crosse County Medical Society, the SMS and the AMA. Dr Matalock is survived by a sister, Carol Craig of Ontario, Canada.

Wayne John Fencil, MD, 69, of Solon Springs, died Sept 8, 1988, in Rochester, Minn. Born June 17, 1919, in Casco, Dr Fencil graduated from Marquette University Medical School and served his internship and residency at Misericordia Hospital in Milwaukee. Dr Fencil joined the Monroe Clinic in 1945 and served in the US Army Medical Corps for two years. He served on the Council of Medical Services with the SMS and headed the executive committee of the Monroe Clinic for many years. Dr Fencil was active in the community affairs of Monroe. He was active in the Apostolate to the Handicapped and also in the American Red Cross. He was a member of the Green County Medical Society, the SMS and the AMA. Surviving are his widow, Irene; a son, Patrick, of Madison; two stepsons, Byron Bennett, of Ham Lake, Minn, and David Bennett, of Coon Rapids, Minn; and a stepdaughter, Julienne Bennett of San Francisco, Calif.

Edward P. Onderak, MD, 61, of Roscoe, died Sept 16, 1988, in Rockford, Ill. Born March 17, 1927, in Crystal Falls, Mich, Dr Onderak graduated from Marquette University School of Medicine and served an internship at St Vincent Hospital, Toledo, Ohio. His residency was completed at Wyandotte General Hospital in Michigan. Dr Onderak practiced in Beloit as a family practitioner from 1955–1960. He completed a radiology residency at Lutheran General Hospital, Milwaukee, and was a staff radiologist at Saginaw General Hospital in Michigan. He opened his medical practice of radiology in Beloit in 1970. He was chairman of the department of radiology at Beloit Memorial Hospital and had served as president of the Beloit Hospital medical staff. Dr Onderak served as president of the Rock County Medical Society, and was a past delegate of the SMS. He was a director and member of the Wisconsin Radiological Society, member of the Rock County Medical Society, the SMS and the AMA. Surviving are his widow, Helen; eight daughters, Mary Madaus, of Roscoe; Therese Galatowitsch, of St Paul, Minn; Nancy Kelly, of Elgin, Ill; Julie Weber, of Glendale, Ariz; Susan Onderak and Polly Onderak, of Milwaukee; Kristin Onderak, of Beloit, and Anne Onderak at home; four sons, John, South Beloit, Ill; Mark, of Ottumwa, Iowa; James, of Davenport, Iowa, and Matthias of Roscoe.

Garrett A. Cooper, MD, 84, of Madison, died Oct 1, 1988, in Madison. Born July 24, 1924, in Watertown, Dr Cooper graduated from the University of Wisconsin Medical School, Madison. His internship was served

at City Hospital in Cleveland, Ohio, and his residency in dermatology was completed at Lakeside Hospital in Cleveland. In 1931 Dr Cooper took a pharmacology research assistant's job with Parke-Davis Pharmaceutical Company. His work consisted of testing arsenical drugs for their effect on syphilis patients. This resulted in Mapharsen, the drug of choice for syphilis before penicillin. Dr Cooper began his private medical practice in Madison in 1939. He was associated with the University of Wisconsin Medical School department of dermatology and received his emeritus professor status in 1977. He was appointed to the State Board of Health in 1967. Dr Cooper retired from private practice in 1977 but continued his consulting and teaching at the Veterans Administration Hospital in Madison. A past president of the Dane County Medical Society and twice president of the Wisconsin Dermatological Society, Dr Cooper was chairman of Madison's Community Welfare Health Panel and in 1961 served as chairman of Dane County's health and hospital survey. Dr Cooper had served on the editorial board of the Wisconsin Medical Alumni *Quarterly* and also had been a member of the editorial board of the *Wisconsin Medical Journal* from 1953–1988. He was a member of the SMS and the AMA. Surviving are his widow, Helen; three daughters, Susan C. Broenkow, of Pebble Beach, Calif; Judy H. Cooper, of Juneau, Alaska, and Gail C. Buschke of Cross Plains.■

CES Foundation
of the State Medical Society of Wisconsin

The persons and organizations named below made contributions to the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin during the month of September, 1988. The Foundation and the Society salute their generosity.

Voluntary contributions
Betty J. Bamforth, MD
Bradley G. Garber, MD
Karl P. Grill, MD
Loren E. Hart, MD
Eric S. Heaney, MD
R. R. Liebenow, MD
David J. Matteucci, MD
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Kenneth M. Viste, MD
Elizabeth Yao

Memorials
Thomas and Diane Adams
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Dr Richard and Nancy Edwards
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Norma Swenson
Joseph Thering
Mildred Voyles
Terri and Dan Weaver
Margaret and Larry Wiersum

Memorialized
Gerhardt R. C. Anderson, MD
Clara Bradley
Clara and Byron Bradley
Isidore A. Davidhoff, MD
Wolfgang O. Dietsche, MD
David T. Dresen
Guy Kempthorne
Stanley R. Miller, MD
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Beaumont 500 Pledge
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Janice and LeRoy Johnson
Kathy and Bob Mohelnitzky
Norma Swenson

Earl R. Thayer Lecture Fund
Thomas and Diane Adams
Dr and Mrs Gerald Kempthorne
Kathy and Bob Mohelnitzky
Marie Shipley
Terri and Dan Weaver
Margaret and Larry Wiersum

Workshop on Health
State Medical Society of Wisconsin

Museum Refurbishment
Pfizer Pharmaceutical■

Membership update

The following information is being provided from membership reports and from individual members for updating the 1988 Membership Directory as published in the August 1988 issue of the *Wisconsin Medical Journal*. Because of space limitations, address changes and phone numbers will not be included in this update, although they will be changed in the SMS membership records.

County transfers will be included when processing has been completed by the membership records staff.

Changes in practice specialties (as used by the AMA) and changes in board-certified specialties as listed by the American Board of Specialties (see August 1988 Membership Directory) are included. Practice specialties appear before the slash (/) and board-certified specialties appear after the slash.

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RHU/IM

Banas MD, John S.
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Staff changes: Ron Henrichs leaves for AMA

During the past two months, three new staff members have joined the SMS, one announced his resignation, and five others were reassigned within the organization.

Ron Henrichs left his position as director of the Division of Communications during the first week of November to join the AMA in Chicago as director of the Department of Young Physician Services. Thomas L. Adams, secretary and general manager of the SMS, has appointed Deborah Bowen Wilke to replace Henrichs as head of communications. Wilke was previously assistant director of the Division of Public Affairs and an SMS field staff representative for District 2.

Three new staff members recently joined the SMS. Kathy Frost moved to Madison from Stevens Point, where she worked for Sentry Insurance. She is a secretary in the Division of Medical Policy and Practice. Mary Barham also recently joined the MPP staff. A policy analyst, Barham worked as administrative assistant to the physician-in-chief at Kaiser Hospital in the San Francisco area. In that position, she specialized in medical ethics, risk management and physician management issues related to health maintenance organizations. The third new staff member is Doug Turecek, SMS computer support technician. Previously, he was a part-time instructor at the Madison Area Technical College and was self-employed as a consultant to small businesses setting up computer systems.

In other staff news, Adams has named Kristin Bjurstrom Krueger, who previously directed the CES Foundation, manager of Meeting Planning and Continuing Medical Education. She will be assisted in this effort by Lisa Lawry. Under a recent reorganization plan, foundation management has been transferred to the secretary-general manager's office; Jean Steele has been appointed special assistant to the secretary for foundation administration. Kathy Mohelnitzky, who previously worked on foundation matters with Krueger, has become administrative assistant for Association Management Services, succeeding Steele.■

Blue Book update

Please refer to page 114 of the July 1988 Blue Book edition of *WMJ*, under the heading of presidents and secretaries and change your records accordingly.

Wisconsin Society of Anesthesiologists
John F. Kreul, MD, president
21 Oxwood Circle
Madison, WI 53717

Jay J. Kuritz, MD, president elect
2412 Sandy Lane
Green Bay, WI 54302

On page 112, under "Officers of specialty sections of the State Medical Society of Wisconsin," the new chairman of the Anesthesiology section is John R. Kruel, MD, 21 Oxwood Circle, Madison, WI 53717.■

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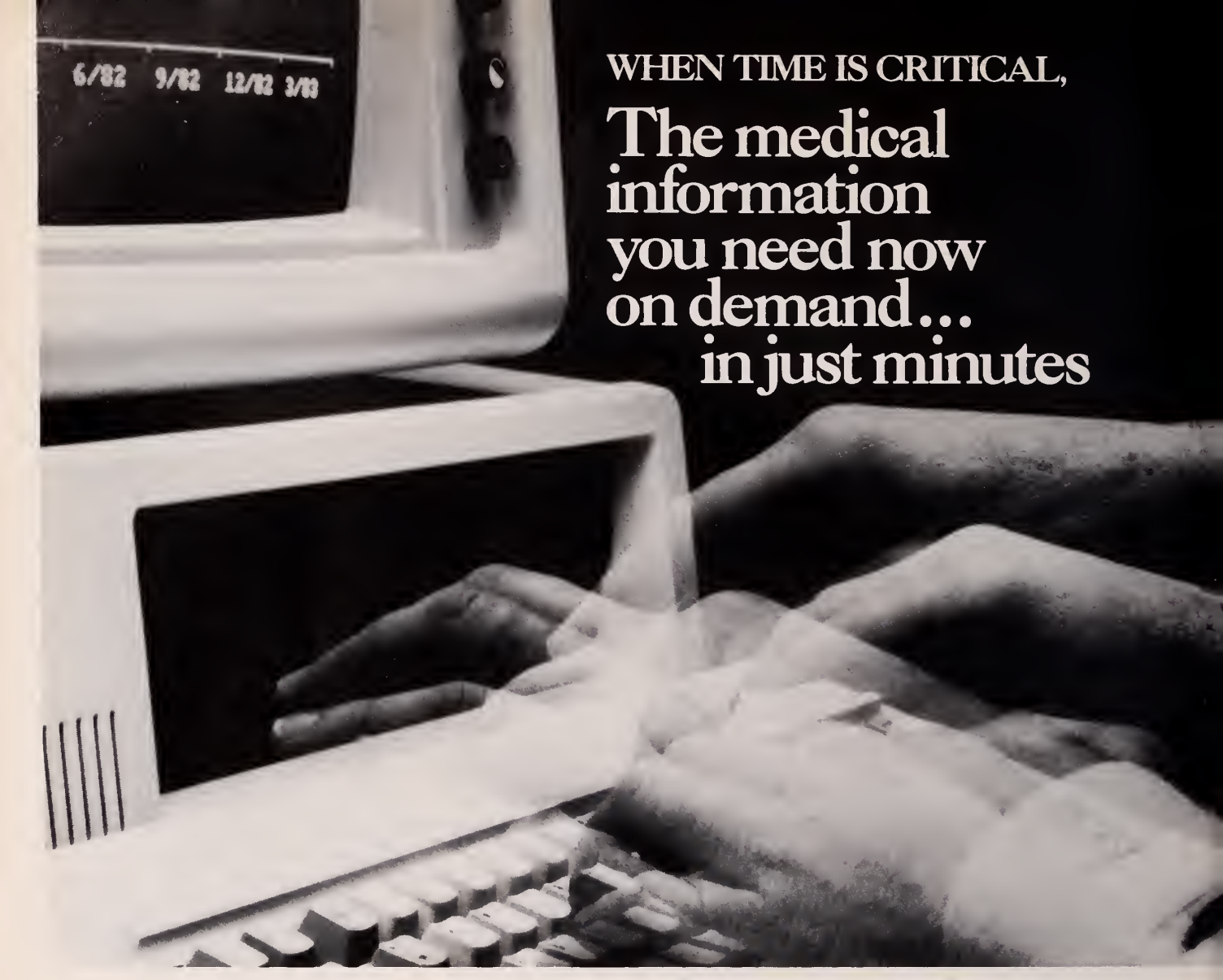

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Physicians Exchange

Minneapolis, Minnesota. Two (2) positions available for BE/BC OB/GYNs at Bloomington-Lake Clinic, a multi-specialty clinic, with two (2) locations and a third clinic opening in Eagan in November. Competitive salary and benefits provided. Please contact: Scott M. Lindblom, Physician Recruiter, Fairvew Physician & Clinic Services, 2312 South 6th St, Minneapolis, MN 55454 or call 612-371-6235; toll-free is 1-800-328-4661, ext 6235. 12/88;1/89

Nevada. Family Practice, Internal Medicine, Pediatrics, OB/GYN, Radiology. Immediate openings in several rural communities; guaranteed salary, full benefits including paid malpractice, and possible university affiliation. No fee to applicant. Contact Sherry Semiatin, Office of Rural Health, Reno, NV 89557-0046; ph 702-784-4841. 12/88

Staff psychiatrist. Rock County, located between Madison and Chicago, is seeking a leader for a multi-disciplinary treatment team. Opportunity to serve a 16-bed acute psychiatric unit with an average length of stay of seven days and a nine-bed detoxification unit with an average length of stay of three days. BC/BE for Wisconsin license preferred. Successful applicant will be expected to reside in Rock County. Salary from $80,000 to $100,000 plus excellent benefits. Contact Dennis Kirchoff, Program Director 608-755-2535. Vita or resume may be sent to Rock County Personnel Department, 51 South Main St, Janesville, WI 53545. An Equal Opportunity Employer. 12/88

General surgeon to join a 12-physician multi-specialty group practice. Rural, college town 30 miles from St Paul, Minn, with community hospital. Contact R. M. Hammer, MD, River Falls, WI 54022; ph 715-425-6701 or 612-436-8809. 12tfn/88

RATES: 50¢ per word, with a minimum charge of $20.00 per ad. BOXED AD RATES: $25.00 per column inch. *All ads must be prepaid.*

DEADLINE: Copy must be received by the 1st of the month preceding month of issue; *eg,* copy for the August issue is due July 1. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free in Wisconsin: 1-800-362-9080.

West Bend, Wisconsin, General Clinic, a 20-physician multispecialty group is seeking additional B/C, B/E physicians in **Family Practice, Pediatrics, OB/GYN, Internal Medicine, Urology, Dermatology,** and **ENT.** First-year salary and benefits guaranteed. Corporate association after one year. Located in a family-oriented, economically strong small city surrounded by four-season recreational and scenic Kettle Moraine area 30 miles north of metropolitan Milwaukee. Contact Hans W. Schmelzling, Administrator, 279 S 17th Ave, West Bend, WI 53095; ph 414/338-1123. 7tfn/87

Family Practitioner to associate with a highly successful two physician (one physician near retirement) rural family health center with an excellent support staff and unlimited potential. Complete fee-for-service practice with excellent hospitals and specialty support only minutes away. Guaranteed salary, incentives and benefits tailored to fit your needs. Located 15 minutes from a major metropolitan area and 30 minutes from the joys of Door County. Interested physicians please contact: J. C. Majeski, Clinic Mgr, Luxemburg Medical Clinic, PO Box C, Luxemburg, WI 54217; ph 414-845-2351. p11-12/88;1/89

Two full-time emergency physicians, board-certified or eligible, are needed to staff Level II Emergency Department with annual volume of 30,000. Residents rotate through department making excellent teaching opportunity. Compensation package exceeds 120,000/yr. Flexible scheduling, 36 hr/wk, 1656 hr/yr. Partnership available in one year. Contact Sunil Ahuja, MD, FACEP, Medical Director, Emergency Services, Sinai Samaritan Medical Center, 2000 W Kilbourn Ave, Milwaukee, WI 53233; ph 414-937-5989. 12/88;1-2/89

Psychiatrist/Chemical Dependency. Psychiatrist interested in chemical dependency needed to join 220-physician multispecialty group with adjacent 447-bed hospital. Position includes inpatient services for Chemical Dependency Unit with full range of outpatient chemical dependency services available; Evaluation and Detoxification Unit; outpatient chemical dependency clientele and follow-up; general psychiatric practice also available. Behavioral Medicine Department is presently staffed by seven psychiatrists, one child/adolescent psychiatrist and two psychologists. New clinic building recently completed. Gundersen Clinic, Ltd, is located in La Crosse, Wisconsin, a progressive community of 50,000 built along the shores of the Mississippi River amid scenic bluffs, the city offers excellent recreational facilities. Numerous educational and cultural opportunities are provided by an expanding university with undergraduate and graduate degree programs, and a private liberal arts college. Excellent pension program, no investment required. Service organization. Write: Philip J. Dahlberg, MD, Chairman, Personnel Committee, Gundersen Clinic, Ltd, 1836 South Ave, La Crosse, WI 54601. An Equal Opportunity Employer. 12/88

Obstetrics and Gynecology. Confidence in this opportunity's success is high, and is reflected by the income guaranteed. Northeastern Midwest; 100,000 in metro area. Dynamic 400 plus bed hospital with excellent step-up Level I nursery, state-of-the-art technological support, Level III nursery within 20 minutes. Complete package includes malpractice and full practice management services. Only board-certified/board eligible specialists. Respond in confidence to: Jim Huber, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186, or call collect 414-785-6500. 12/88;1/89

Minneapolis. Multiple opportunities available for Obstetricians at Riverside Medical Center. Option to work with midwives and be active in a teaching program for OB/GYN and Family Practice residents. Competitive salary and benefit package. Send curriculum vitae to: Scott M. Lindblom, Physician Recruiter, Fairview Physician and Clinic Services, 2312 South 6th St, Minneapolis, MN 55454, or call 612-371-6235; toll-free 1-800-328-4661, ext 6235. 12/88;1/89

Immediate opening for family practitioner to join busy 13-physician multispecialty group in clean North Dakota lake country. Salary and fringe benefits very liberal. Send curriculum vitae or inquires to: Lake Regional Clinic, PC, PO Box 1100, Devils Lake, ND 58301, Attn: Joel Rotvold or call collect at 701-662-2157 for further information. 11-12/88;1/89

Come join me. Ambulatory care. Orange County, California. Good Hours. Great wages. Excellent amenities. Gerald J. Derus: 714-496-8641. 11tfn/88

Orthopaedic Surgeon. Board-certified/eligible to join two well established orthopaedists in an actively expanding multispecialty southern Wisconsin clinic. New medical facility in a growing community of 50,000+. Modern "state of the art" hospital. Send CV to James Lube, Administrator, Janesville Medical Center, Ltd, 3524 East Milwaukee St, Janesville, WI 53546 or call 608-756-7122. 11-12/88;1/89

Physicians Exchange

continued

Family Practitioner. Family practice physician wanted to be associated with branch clinic of a large multi-specialty group. Opportunity for family practice in Prairie du Chien, Whitehall, Viroqua or Tomah, Wisconsin; West Union, Iowa. Physician would be associated with a multi-specialty group. Relief provided for vacations, meetings, etc. Educational opportunities through an excellent education program. Beautiful countryside, cultural and recreational facilities. Excellent fringe benefits. Salary commensurate with background and experience. Write or call: Tim Skinner, MSEd, Family Practice Representative, Gundersen Clinic, Ltd, 1836 South Avenue, La Crosse, WI 54601. Equal Opportunity Employer. 12/88

Seeking emergency department director and full-time physicians for 100-bed hospital 35 miles north of Milwaukee. Excellent compensation, malpractice insurance provided and benefit package provided. Contact: Emergency Consultants, Inc, 2240 S Airport Road, Room 36, Traverse City, MI 49684; ph 1-800-253-1795 or in Michigan 1-800-632-3496. 12/88

Lake Winnebago, Wisconsin area. Seeking director, full-time and part-time emergency physicians for low volume 60-bed hospital. Attractive compensation, full malpractice insurance coverage and benefit package available. Contact: Emergency Consultants, Inc, 2240 S Airport Road, Room 36, Traverse City, MI 49684; ph 1-800-253-1795 in Michigan 1-800-632-3496. 12/88

Northern Wisconsin
Family Practice physician to join multi-specialty group practice in Woodruff, Wis. Guaranteed annual income and excellent fringe benefit program. Send CV to R.J. Sloan, MD, Lakeland Medical Associates, Ltd, PO Box 549, Woodruff, WI 54568. 12tfn/88

NEW PHYSICIANS FOR WISCONSIN
is seeking
- Family Physicians
- Pediatricians
- Orthopedic Surgeons
- Internists

Contact: Fred Moskol
UW Office of Rural Health
810 University Bay Drive
Madison, WI 53705
608/263-7933
7–12/88;1–6/89

Family Practitioner needed by progressive and stable HMO in west central Wisconsin city of 50,000. Highly competitive salary with excellent fringe. Practice high quality care in a good recreational area. Send CV to Robert Braastad, MD, 1030 Regis Court, Eau Claire, WI 54701; ph 715-836-8552. p10–12/88

Family Practice. Three-man group in Fort Atkinson, Wisconsin, seeking BC/BE family practitioner to fill position of retired partner, Full benefits, salary guarantee, opportunity to join SC after one year. 110-bed remodeled community hospital one block from office. All the benefits of rural living with access to urban areas in 30 minutes. Contact: Fort Atkinson Medical Center, 211 Memorial Drive, Fort Atkinson, WI 53538; ph 414-563-2404. p11–12/88

Twenty-nine physician multispecialty clinic located in desirable East Central Wisconsin location is seeking Board-certified or Board-qualified orthopedic surgeon to round out its services. Lab, x-ray, excellent hospital. Liberal guarantee and benefits. If interested contact D.F. Sweet, MD, Fond du Lac Clinic, SC, 80 Sheboygan St, Fond du Lac, WI 54935. 9tfn/87

Aspen Medical Group, an independent, multi-specialty group with eight clinic locations in the Minneapolis/Saint Paul metropolitan area, seeks associates in Family Practice, Internal Medicine, Obstetrics/Gynecology, Orthopedic Surgery. Competitive earnings, excellent benefits, reasonable call and clinic responsibilities. Reply: Maureen Reed, MD, Aspen Medical Group, 1295 Bandana Blvd, North, Suite 310, Saint Paul, MN 55108 or call 612-642-2707. 12/88;1–2/89

Family practice. Thirty-four physician multispecialty group conveniently located between Chicago and Milwaukee. Well-equipped clinic offering salary guarantee with incentive bonus; excellent fringe benefits and early ownership. Please send current curriculum vitae to Roger D. Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 4tfn/88

Beloit Clinic, SC, an expanding multispecialty group in southern Wisconsin college town is seeking a pulmonologist, radiologist, allergist, ophthalmologist, and orthopaedic surgeon for its main facility, as well as a second family practitioner for a satellite location. Guaranteed salary with incentive plus excellent fringe benefits. Send CV to J. F. Ruethling, Administrator, 1905 Huebbe Parkway, Beloit, WI 53511; ph 608-364-2200. 10–12/88;1–3/89

Family Practice—Madison, Wisconsin. Eleven-year-old staff model HMO has a family practice position available. We offer a very attractive practice setting with reasonable scheduling, excellent salary, and benefits. Contact John Hansen, MD, Medical Director, Group Health Cooperative, One South Park, Madison, WI 53715; ph 608-257-9700. 12tfn/88

Family practice opportunities in a group setting. Located in a family oriented economically strong small city. Located near lakes and metro area. Contact Andrew V. Lagatta, President & CEO, Clintonville Community Hospital, 35 North Anne St, Clintonville, WI 54929; ph 715-823-3121. p12/88;1–5/89

Pediatrics. Marshfield Clinic, a 270-physician, multispecialty private group practice, is seeking a board-certified or eligible general pediatrician to join its expanding regional center in Chippewa Falls. Chippewa Falls is a community of 15,000 people located in beautiful west central Wisconsin with a wide range of recreational, educational, and cultural opportunities easily accessible. The clinic is adjacent to a 110-bed JCAH accredited hospital. Competitive salary and fringe benefit package. Send curriculum vitae and references to: Mr David Draves, Director, Regional Development, Marshfield Clinic, 1000 North Oak Ave, Marshfield, WI 54449 or you may call collect at 715-387-5376. 12/88

Internist BE/BC. North Shore Internal Medicine, PC, is seeking an energetic general internist to enjoy the benefits of a rapidly expanding practice. New office close to hospital. Michigan State Medical School Campus. Send resume to 2420 First Ave, South, Escanaba, MI 49829; ph 906-786-1563. 10tfn/88

Northern Wisconsin
Internal Medicine physician to join multi-specialty group practice in Woodruff, Wis. Guaranteed annual income and excellent fringe benefit program. Send CV to R.J. Sloan, MD, Lakeland Medical Associates, Ltd, PO Box 549, Woodruff, WI 54568. 12tfn/88

La Crosse, Wisconsin. Immediate opening for a walk-in clinic physician. Affiliated with 55-physician multi-specialty group. Regular hours, no call or inpatient responsibilities, competitive salary and benefits. Full- or part-time. Call or write: P. Stephen Shultz, MD, Medical Director, Skemp Clinic, 815 S 10th St, La Crosse, WI 54601; ph 608-782-9760. p12/88

Physicians Exchange

continued

BC/BE General Internist to join 26-MD multispecialty group with four internists, one nephrologist and one gastroenterologist. Top salary first year, full incentive thereafter. Central Wisconsin university town with drawing area of 80,000. Send CV to Dr John Gauder, Rice Clinic, SC, 2501 Main St, Stevens Point, WI 54481, or call collect 715/344-4120. 12tfn/87

Rheumatologist—the Racine Medical Clinic, a 34-physician multispecialty group conveniently located between Chicago and Milwaukee. Well equipped clinic offering salary guarantee with incentive bonus; excellent fringe benefits and early ownership. Please send curriculum vitae to: R.D. Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406. 11tfn/87

General and Vascular Surgeon, university trained, sought as ambitious associate for very busy surgeon. Rewarding, hard work in sophisticated medical community. Robert Mikkelsen, MD, FACS, 14 N Main St, Fond du Lac, WI 54935. p8;9–11tfn/88

Career opportunity for qualified Emergency Room physician. Our group covers two hospital emergency rooms and an active walk-in clinic in southeastern Wisconsin. Full fringe benefit package and flexible scheduling offered. Interested parties contact John W. Linstroth, MD, 1201 Sherwood Lane, Caledonia, WI 53108; ph 414-835-7761. 8tfn/88

Northern Wisconsin
Pediatric physician to join multispecialty group practice in Woodruff, Wis. Guaranteed annual income and excellent fringe benefit program. Send CV to R.J. Sloan, MD, Lakeland Medical Associates, Ltd, PO Box 549, Woodruff, WI 54568. 12tfn/88

Eagle River—Great opportunity for two BC/BE family practice physicians to join well-established practice. Guaranteed annual income and future partnership available. For more information, send resume to Judy Harris, Recruiter, UW Office of Rural Health, 810 University Bay Dr, Madison, WI 53705 or call collect 608/263-7933. 1tfn/88

Wisconsin. OB/GYN (BC/BE) needed to join dynamic HMO-based multispecialty group practice. University town of 55,000 near Minneapolis. Community and recreation outstanding. Competitive salary and fringes. We take pride in our patient care. Contact Robert A. Braastad, MD, Group Health Cooperative, 1030 Regis Court, Eau Claire, WI 54701; ph 715-836-8552. p11–12/88;1–89

The Wausau Medical Center is seeking BC/BE individuals in the following specialties: Cardiology, Dermatology, Family Practice, Infectious Disease, Obstetrics/Gynecology, Pediatrics and Rheumatology. Modern clinic facility located across the street from modern 300-bed hospital. Full partnership in three years. Easy access to lakes, woods and mountains. Write including CV to D.K. Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, WI 54401. p4tfn/88

Wisconsin—Emergency Medicine. Excellent clinical opportunities are currently available with Spectrum throughout Wisconsin. Low to moderate volume emergency departments. Varying schedules available. Guaranteed competitive rate of reimbursement, high-limit occurrence malpractice insurance coverage, Wisconsin Compensation Fund. For additional information, contact Ruth Sutterer, Spectrum Emergency Care, PO Box 27352, St. Louis, MO 63141; ph 1-800-325-3982, extension 3029. 11–12/88;1/89

Independent practice opportunity, Eau Claire, Wis. Extremely busy Board-certified solo family practitioner seeks one to two FP associates. Practice located in newly 1987 constructed 11,000 square foot professional building which also houses a plastic surgeon, podiatrist, and pharmacy. Due to the size of the practice, an outstanding initial employment and compensation package is being offered as well as very attractive associate terms for full partnership after one year. Contact Donald Stewart at 414-731-3004 for additional information. 10–12/88

Minnesota Internist seeks BE/BC internist to join his practice in Brainerd, a central Minnesota resort community. Beautiful lakes and expanding retirement area. New 162-bed hospital with all specialties. Offices in five year-old medical office building. Contact Michael O. Musty, MD, 1903 South Sixth St, Brainerd, MN 54601; ph 218-828-4082. 11tfn/88

Eastern Iowa. Progressive young BC FP seeks residency trained BC FP for growing practice. Call every fourth night. Newly remodeled hospital. Active community 19 miles from Iowa's third largest city. Send CV to S. Hanas, MD, 1118 11th, DeWitt, IA 52742. 10–12/88

Physicians needed full- or part-time to perform light physicals. Milwaukee area. Professional liability provided. Phone 414/344-2100, Ms Jenkins. 10tfn/84

Miscellaneous

For sale. Medical equipment, used but in excellent condition. Exam tables, cabinets, diagnostic equipment. Call 608-837-6984. p12/88;1/89

For sale. 33' cross-country motorhome; two air conditioners; 6.5 KW generators; 6,500 miles, $35,000 or best offer. Call 414-781-0289. p12/88

Real Estate

For Rent. Doctor's Office, Hales Corners, Wisconsin, area 1050 sq ft. New building, first floor, ample parking. Reception, business office, three plumbed examining rooms, laboratory, private office and bath. For information call 414-764-6692 or 414-744-8007. 8tfn/88

For Rent. Milwaukee, Wisconsin. Courtland Medical Center, 68th and Capitol Drive. Premium physician's space available with up to nine examining rooms. Diagnostic laboratory and pharmacy on premises. Ample parking. Many incentives besides below market rates. Please contact H & H Investments at 414-246-8029. p12/88

1989 ANNUAL MEETING

STATE MEDICAL SOCIETY OF WISCONSIN

AT THE MECCA
MILWAUKEE (Hyatt Hotel)

APRIL 13–15

Medical Meetings—Continuing Medical Education

MARCH 5–10, 1989: Cardiology for the Clinician: Practical Guidelines for Merging Advances in Cardiology with Bedside Medicine at Snowmass, Colorado. (Further details elsewhere in this section.) g11-12/88

JUNE 21–24, 1989: Wisconsin Academy of Family Physicians, Radisson Hotel, La Crosse g11tfn/88

SEPTEMBER 8–10, 1989: Wisconsin Society of Anesthesiologists, Lake Lawn Lodge, Delavan. 12tfn/88

SEPTEMBER 14–16, 1989: Wisconsin Society of Internal Medicine, Embassy Suites, Green Bay, Wisconsin. g11tfn/88

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, clinics, specialty societies, and medical schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 50¢ per word, with a minimum charge of $20.00 per listing. *All listings must be prepaid.*

BOXED LISTINGS: $25.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 1st of the month preceding the month of publication; *eg,* copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free in Wisconsin: 1-800-362-9080.

FOR LISTING of other meetings see the July 1, 1988 issue of the *Journal of the American Medical Association:* Continuing Education Opportunities for Physicians for period August 1988 through December 1988.

AMA

JUNE 18–22, 1989: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 3–6, 1989: Interim House of Delegates, Honolulu, HI.

JUNE 24–28, 1990: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 2–5, 1990: Interim House of Delegates, Orlando, FL.■

Wisconsin Specialty Society Meetings: 1989

Wisconsin Orthopaedic Society, May 5, 1989, American Club, Kohler.

Wisconsin Chapter: American Academy of Pediatrics, May 22, 1989, Milwaukee.

Wisconsin Academy of Family Physicians, June 21–24, 1989, Radisson Hotel, La Crosse.

Wisconsin Society of Obstetrics & Gynecology, July 20–22, 1989, Radisson Hotel, La Crosse.

Wisconsin Society of Anesthesiologists, Sept 8–10, Lake Lawn Lodge, Delavan.

Wisconsin Society of Internal Medicine, Sept 14–16, 1989, Embassy Suites, Green Bay

CONTINUING MEDICAL EDUCATION

Sponsored by Marshfield Clinic
Marshfield, Wisconsin

JANUARY 25–27, 1989: *Cancer 89,* Telemark Lodge, Cable

FEBRUARY 4, 1989: *Science Teachers Conference,* Marshfield

FEBRUARY 9–10, 1989: *Winter Pediatric Conference,* Big Powderhorn Ski Resort, Bessmer, Michigan

MARCH 24–25, 1989: *Advanced Cardiac Life Support Course,* Marshfield

Further information or a brochure call the Marshfield Clinic's Office of Medical Education, 1000 North Oak Ave, Marshfield, WI 54449; ph 715-387-5207. 9-12/88

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State Medical Society of Wisconsin

Dates and locations of
ANNUAL MEETINGS
1989–1993

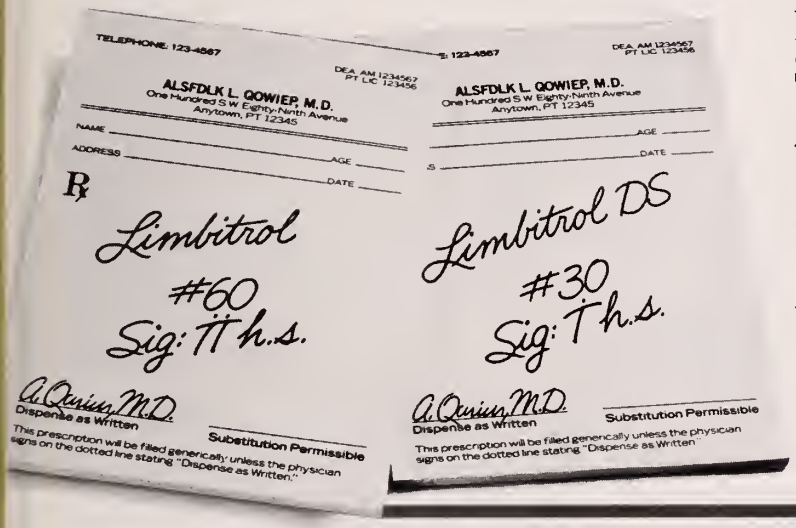
All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel, unless otherwise indicated.

1989—April 13–15
1990—April 26–28: Green Bay Convention Center, Embassy Suites
1991—April 18–20: Milwaukee Wyndham Hotel
1992—April 23–25
1993—April 15–17: La Crosse Convention Center, Radisson

Meetings days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.
Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, WI 53701. Local Telephone: 257-6781; toll-free in Wisconsin: 1-800-362-9080.

In moderate depression and anxiety

- 74% of patients experienced improved sleep after the first *h.s.* dose[1]
- First-week improvement in somatic symptoms[1]
- 50% greater improvement with Limbitrol in the first week than with amitriptyline alone[2]



Protect Your Prescribing Decision: Specify "Do not substitute."

Limbitrol®

Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) Ⓒ IV

Limbitrol® DS

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) Ⓒ IV

References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Feighner VP, *et al: Psychopharmacology 61*:217-225, Mar 22, 1979.

Limbitrol® Ⓒ IV
Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.**

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady- state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. *Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. *Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. *Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. *Endocrine:* Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

How Supplied: *Double strength (DS) Tablets,* white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets,* blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

ROCHE®

ROCHE PRODUCTS INC.
Manati, Puerto Rico 00701

P1. 0288

In the depressed and anxious patient

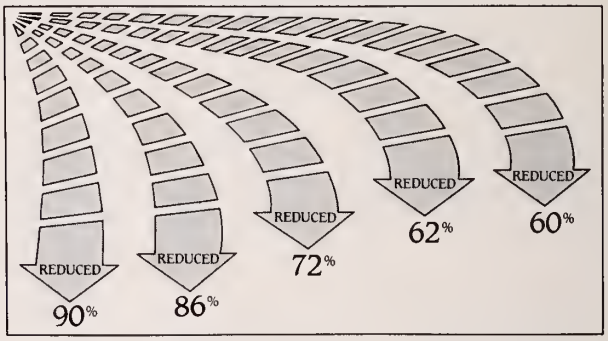
See Improvement In The First Week[1]...

And The Weeks That Follow

- 74% of patients experienced improved sleep after the first *h.s.* dose[1]
- First-week reduction in somatic symptoms[1]

Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

Percentage of Reduction in Individual Somatic Symptoms During First Week of Limbitrol Therapy*



*Patients often presented with more than one somatic symptom.

Limbitrol®

Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) Ⓒ IV

Limbitrol® DS

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) Ⓒ IV

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